DOCUMENT RESUME

ED 313 598 CG 022 116

AUTHOR	Pierce, Don; McClain, Robert
TITLE	Missouri Curriculum Guide for Alcohol and Drug Education Programs.
INSTITUTION	Missouri State Dept. of Mental Health, Jefferson City. Div. of Alcohol and Drug Abuse.
REPORT NO	D.M.H.-Bulletin-10.050
PUB DATE	May 88
NOTE	191p.; For related document, see CG 022 115. Italicized or "filled" type may film marginally.
PUB TYPE	Guides - General (050)
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	Adolescents; *Alcohol Abuse; *Correctional Education; Drinking; Driving While Intoxicated; *Drug Abuse; *Drug Education; *Prevention; *Substance Abuse; Young Adults
IDENTIFIERS	*Missouri

ABSTRACT

This document presents the Alcohol and Drug Education Programs (ADEP) curriculum guide developed by the Missouri Department of Mental Health to provide education programs for individuals under the age of 21 convicted of certain alcohol and drug related offenses. An introduction is followed by a section on substances of abuse and their effects. Basic terms and concepts are defined, and a number of substances are considered individually: alcohol, tobacco, marijuana, cocaine, stimulants, sedatives, hallucinogens, narcotics, and inhalants. The use of substances in combination is discussed, high risk substance use is defined, and the risk of Acquired Immunodeficiency Syndrome is explored. The next section looks at the effects of substance use on driving skills. It examines the magnitude of the drinking and driving problem and explains the effects of alcohol and of marijuana on driving skills. A section on substance abuse and dependency discusses the disease concept, genetic factors, the progression of dependency, recognition of substance abuse and dependency, the effects on the family, and treatments available for adolescent substance abusers. A section on life skills discusses motivations, decision-making skills, refusal skills, and alternatives to use. Six tasks that need to be accomplished in the concluding phases of the program are listed; sample forms, program operations, and resource materials are appended. (NB)

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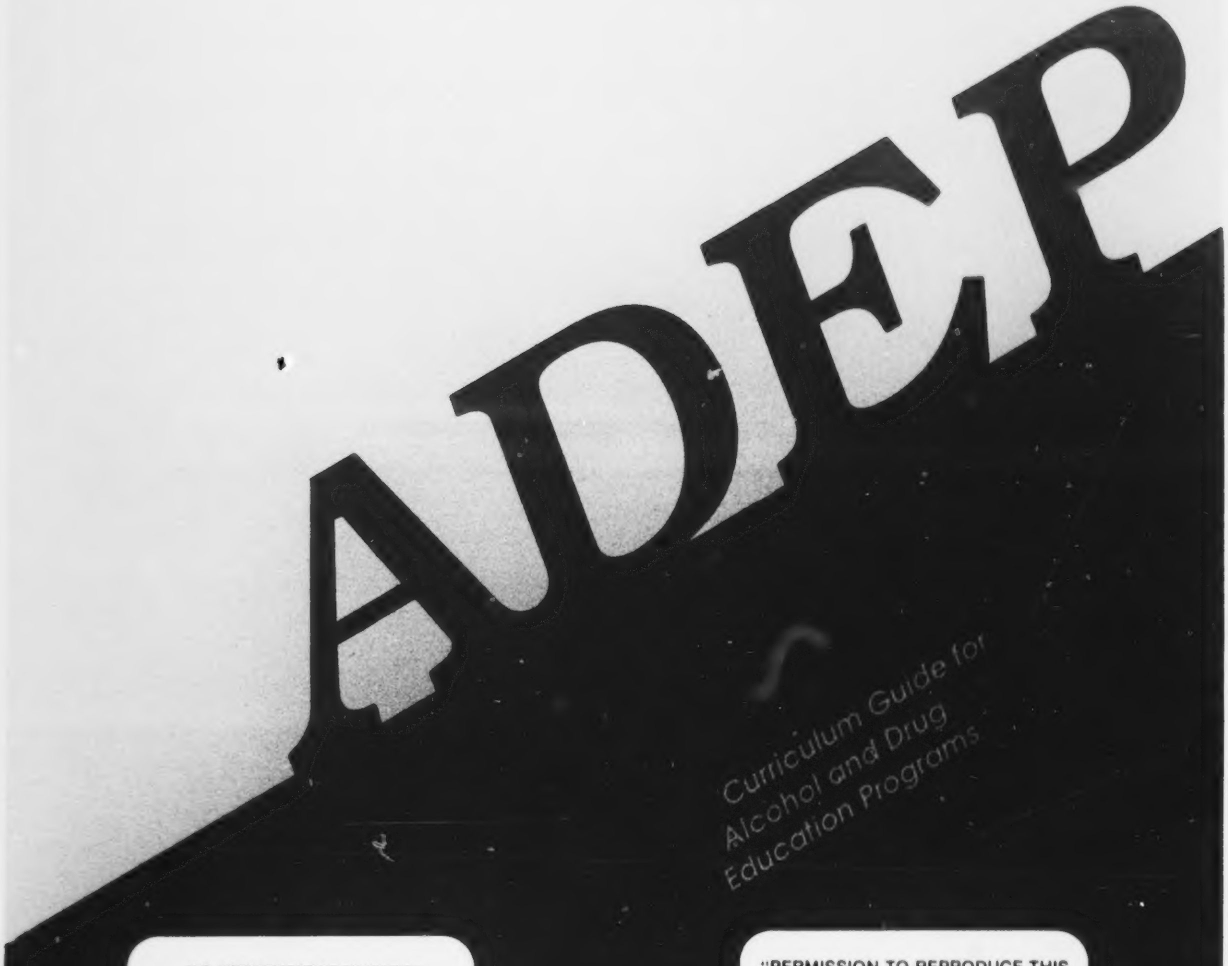

ADEP

Curriculum Guide for
Alcohol and Drug
Education Programs

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May, 1988

Dear ADEP Administrators, Professionals, and Instructors:

In 1987 the Missouri Legislature enacted a statute commonly known as "Abuse and Lose", establishing education programs for those under the age of 21 convicted of certain alcohol and drug related offenses. The legislation also mandated participation in an education program by those convicted for the first time of possessing small amounts of marijuana (35 grams or less). The responsibility for development of standards governing these Alcohol and Drug Education Programs (ADEP) was given to the Department of Mental Health, Division of Alcohol and Drug Abuse. These standards, promulgated under 9 CSR 30-3.700, identify the basic requirements for programs to be certified by the Department. The standards specify content areas to be covered by ADEPs. This curriculum guide provides detailed coverage of the required content areas.

The curriculum guide was developed in consultation with substance abuse treatment, prevention, and education programs from all regions of the State of Missouri. Both public and private sector programs were represented. It is hoped that those who use the guide will find that it is easy to use. The choice of binding was made to facilitate easy insertions of additional material, e.g. new knowledge or any future revisions made by the Division.

The Division of Alcohol and Drug Abuse welcomes your comments and suggestions about this guide.

Sincerely,

Lois Olson

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MISSOURI CURRICULUM GUIDE
FOR
ALCOHOL AND DRUG EDUCATION PROGRAMS

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D.M.H. Bulletin 10.050

First Printing May, 1988

ACKNOWLEDGEMENTS

The Division would like to express its appreciation to members of the Task Force on the ADEP Curriculum Guide who reviewed the preliminary draft and shared their ideas and information:

Al Crandall, Community Counseling Center
Pat Doyen, Missouri Division of Youth Services
Irma Froe, Task Force for Women Alcoholics
Michael Layden, Southeast Missouri Community Treatment Center
Kelly Lenhart, National Council on Alcoholism - Kansa City Area
Milton Mitchell, St. Louis County ARTOP
David Parker, Comprehensive Human Services
Donna Peissner, New Beginnings Recovery Center
Christine Squibb, Ozark National Council on Alcoholism
Ed Tasch, St. Louis Area National Council on Alcoholism
Vicki Williams, Missouri Division of Highway Safety
Herman Wood, Alcohol Education Clinic.

The Division also extends its appreciation to the following individuals for their interest and suggestions:

Jerry Eames, E.S.C.A.P.E.
David Egar, Office of the Courts Administrator
Sergeant E. N. Moses, Missouri State Highway Patrol
David Rasse, Rasse and Associates
Walter Wosilait, Ph.D., University of Missouri-Columbia

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TABLE OF CONTENTS

Foreword 1

Introduction

Orientation of Students 8
Initial Paperwork 9
ADEP Goals 9
Magnitude of Adolescent Substance Use 10
"Abuse and Lose" and Other Laws 12

Substances of Abuse and Their Effects

Basic Terms and Concepts 16
Alcohol 19
—Fetal Alcohol Syndrome (FAS) 21
—Blood Alcohol Concentration (BAC) 24
—Physical Signs and Approximate BAC 26
—Drinking Myths 28
Tobacco 29
Marijuana 30
Cocaine 37
Stimulants 39
Sedatives 40
Hallucinogens 42
Narcotics 44
Inhalants 46
Substances in Combination 47
Acquired Immunodeficiency Syndrome (AIDS) 50
High Risk Substance Use 54

Effects of Substance Use on Driving Skills

Magnitude of the Drinking and Driving Problem 55
Effects of Alcohol on Driving Skills 57
Effects of Marijuana on Driving Skills 59

Substance Abuse and Dependency

Disease Concept 61
Genetic Factors 64
Progression of Dependency 66
Recognition of Substance Abuse and Dependency 68
Effects on the Family 72
Treatment for Adolescent Substance Abusers 76

Life Skills

Motivations 79
Decisionmaking Skills 82
Refusal Skills 87
Alternatives to Use 92

Concluding Tasks 94

Appendix I - Sample Forms

Information Notice to Student. I-1
Parent Acknowledgement I-2
Student Registration I-3
Student Information - Responsibilities, Rights, Grievances. I-4
Authorization for Parent Involvement. I-5
Consent to Release Information I-6
Pre/Post Test I-7
Student Survey I-11
Family Member Questionnaire I-18
Assessment Note I-22
Course Evaluation I-23
Notice of Participation I-24
Notice of Assessment Recommendation I-25
Personal Plan (Student) I-26
Personal Plan (Family Member) I-27
Screening Questionnaire I-28

Appendix II - Program Operations

Disruptive Student II-1
Incident Report II-3
Small Group Interview Method. II-4
Individual Assessment Interview. II-7
Recommendation II-8
Area Resources (Sample Format) II-9
Confidentiality Provisions II-10
Summary of Record-Keeping Requirements II-13

Appendix III - Resource Material

Graph - Motor Vehicle Deaths III-1
Graph - Probability of Crash III-1
Drugs of Abuse III-2
Physical Effects of Drug Abuse III-3
Glossary of Drug Slang III-4
BAC Chart III-6
Drinking Myths III-7
Effects of Marijuana on the Body III-10
AIDS Testing Sites. III-14
Family V-Chart III-15
Children of Alcoholics Screening Test (C.A.S.T.). III-16
Roles of Children of Alcoholics III-18
Levels of Substance Use by Adolescents III-19
Substance Dependence and Abuse (DSM III-R) III-20
Barriers to Treatment III-26
Film Resources III-27
Film Reviews III-29

FOREWORD

Substance abuse continues to be a threat to the well-being of the young people of Missouri. While the popularity of particular substances may fluctuate, the overall incidence of drinking and substance abuse continues at unacceptably high levels. According to information provided by the 1986 National Survey of High School Seniors, nearly three-fifths (58 percent) of all American young people use an illicit drug at least once before they leave high school, and 38 percent have used drugs other than marijuana. Ninety-one percent of all high school seniors have used alcohol; 65 percent used alcohol in the last month. Nearly half (46 percent) of senior boys and more than one-fourth (28 percent) of senior girls report heavy party drinking of five or more drinks in a row on at least one occasion within the two weeks prior to the survey. About one in 20 seniors (5 percent) drinks alcohol daily. In Missouri alone, an estimated 27,000 young people under the age of 19 need treatment for substance problems.

In this curriculum guide, the generic terms "substance", "substance use", and "substance abuse" are generally used, unless there is a specific reason to use the terms "alcohol" or "drug". Substance refers to alcohol or drugs or both.

The purpose of this program is to provide the students with enough clear, accurate information that they are able to reevaluate their past decisions to drink or use illicit drugs. It is hoped that many will decide to avoid or postpone substance use, or at least reduce the amount and frequency of use. These results will lessen the potentially destructive effects of alcohol and drugs in their lives. Another goal is that, through ADEP participation, those who are experiencing substance abuse or dependency will be identified and will be referred to appropriate sources of help.

All or nearly all of the ADEP students should be under the age of 21. Completion of ADEP is required by those under the age of 21 convicted of certain alcohol and drug offenses. Young offenders with convictions for Driving While Intoxicated/Drugged or for Excessive Blood

Alcohol Content should attend ADEP rather than ARTOP (Alcohol-Related Traffic Offenders' Program). It is possible that some ADEP students will be age 21 or older. The "Abuse and Lose" statute mandates participation in an education program, where available, by those convicted for the first time of possessing small amounts of marijuana. ADEP will be the education program utilized for this purpose. Programs are strongly encouraged to conduct special classes for marijuana offenders or for adult offenders, where possible, utilizing the most relevant parts of this curriculum guide. The Appendix contains additional resource materials and suggested films that could be used to emphasize content regarding marijuana.

The ADEP Curriculum Guide can be used as a resource book which is generally followed, or it can serve as a detailed lesson plan to which there is close adherence. Instructors may use relevant personal experiences and examples and may utilize additional resource materials. However, programs must notify and obtain specific Division approval before any substantial alteration in course content or format is made.

The ADEP Curriculum Guide is designed to encourage class discussion, interaction, and sharing, especially in the second half of the program. The first half is more didactic as basic information and concepts are presented about alcohol and drugs of abuse. The second part relies more on class interaction and participation. The curriculum guide is organized into three major units: (1) Substances of abuse including effects on driving skills; (2) Substance abuse and dependency including effects on the family; and (3) Life skills including decisionmaking, refusal skills, and alternatives. Administrative, assessment, and referral functions of the program are woven into the major content areas. Although much of the curriculum guide provides information about Substances of Abuse (including effects on driving skills), this content area is not necessarily the primary or most important one. Approximately half of the course time should be devoted to the topics of Progression of Dependency (including effects on the family) and Life Skills.

Appropriate use of films, volunteer speakers, or other aids to instruction is encouraged. These aids, properly utilized, can add immeasureably to the program. They can relieve boredom, present the information in new and provocative ways and provide the instructor with time to accomplish other necessary tasks. However, use of these aids to instruction as the basis for the program is unacceptable. A list of recommended films is included in the appendix, as well as a directory of film resources and companies.

Audio-visual materials, i.e. films, videos, slides or film strips, can constitute no more than 20 percent of total class time and the use of volunteer guest speakers is also limited to no more than 20 percent of total class time. Programs must have written policy for the recruitment, training, use, and reasons for any dismissal of volunteer speakers. Grounds for dismissal could include, but are not limited to, ineffective speaking, inappropriate or offensive language, improper advances to class members, and/or questionable ethics concerning treatment facilities or self-help recovery programs. The ADEP will maintain a roster of any volunteer speakers outlining their areas of expertise and the volunteer's functions within the program.

ADEP is designed to encourage parent participation, especially for students under the age of 18 who are not emancipated. This participation will provide parents with accurate information, encourage family communication, and may be a force to see that help, when needed, is obtained for the student and family.

Substance abuse by any one family member affects all members of the family unit. Substance abuse does not happen in a vacuum nor does it progress without some form of assistance, either intentional or unintentional, from the family or broader social group. ADEP students are at risk for having or developing chemical dependency. One of the most effective means of reducing substance abuse by youth is for as many people as possible to become educated about chemical dependency and to learn what to do and not to do. ADEP students may also be members of families where a parent may have chemical dependency. Parents and guardians should be included (at no extra cost to the family) in a family awareness portion of the program. Parents are specifically invited to ADEP in the notice that is sent about the class. The Parent Acknowledgement form that accompanies the notice prompts parents to make a conscious, definite committment to attend. (See pages I-1 and I-2 in Appendix I.)

The family awareness portion should include information about substances of abuse and the progression of dependency, including effects on the family. Each concerned family member should prepare a plan of action for themselves, outlining their intended behavior toward the student and the rest of the family. During the family awareness portion of the program, parents should not be blamed for what has happened. The message to give parents is that their awareness and their assistance is crucial to the satisfactory resolution of the incident.

The Life Skills section of the curriculum emphasizes interaction and discussion among the students themselves. The presence of parents can be expected to hinder such participation and discussion. However, a certified ADEP could choose to have a separate and distinct program for parents at those points. A total program for parents is not included within this curriculum guide.

Family members should be invited to participate in the initial notice about the program. This notice should explain the purpose of family participation and the time involved. Included in the notice should be a form to determine the family's willingness to participate. Family members should also be aware that the same expectations which apply to the students, e.g. sobriety and cooperativeness, apply to them also.

ADEP consists of ten (10) hours of education plus time for an individualized assessment, when indicated. (See pages II-4 through II-7 in Appendix II regarding possible assessment methods.) Recommendations must be presented to students, and each student must develop a personal plan of action. A copy of the "Notice of Assessment Recommendation" should be provided to the student, parent (if applicable), and the referring court.

The ADEP Curriculum Guide provides more than enough content for the ten hours of education— especially with the suggested use of films and guest speakers, the encouragement of class discussion and interaction in the Life Skills unit, and the availability of further information in Appendix III. In fact, the instructor may have difficulty fully covering all content areas. The curriculum guide includes certain content areas marked "Optional". These areas would be the first to cover briefly, or even eliminate.

Predictably, students will bring certain issues and resistances to the first ADEP session. Sometimes they will be expressed and sometimes they will remain unspoken. The instructor should be aware of these issues and resistances and be prepared to deal with them. The following are examples of these issues and resistances and suggested instructor responses:

- **Student Issue:** "The system is picking on me because of my age."

  Instructor Responses:

  -- "Why are you disregarding laws which you find inconvenient?"

  -- Cite the statistics indicating overrepresentation of youth in drinking and driving accidents.

  -- Note that the earlier an individual begins drinking or drug use, the more likely he or she is to develop serious problems later.

  -- Point out that almost all societies tend to look out for and take care of its members, especially the young or old.

- **Student Issue:** "Marijuana is not a dangerous substance and probably is less harmful than alcohol."

  Instructor Responses:

  -- Reiterate the law issue.

  -- Note that all psychoactive drugs retard emotional development and many cause physical problems. There is no "safe" high and that includes marijuana.

-- Point out that all the facts are not in, and research continues into the effects of marijuana. However, the more that is discovered, the more we learn of marijuana's harmful effects. Besides health considerations for the user, marijuana is an intoxicating drug that makes learning difficult. Complicated abilities like driving a car are impaired, and this creates a danger for others.

-- Indicate that our society already has two legal substances—alcohol and tobacco—due to a long history and acceptance of use. These two substances already create many health and social problems. Our society is not ready for a third legal substance and its negative consequences.

- **Student Issue:** "I'm a victim of circumstances. I just got caught."

Instructor Responses:

-- Studies indicate that there is a difference between those with alcohol and substance offenses and the general population. In one study, those with underage drinking offenses, compared to others of their age, were found to binge drink more often, use drugs more often, have more friends who drink and use drugs, and have a greater incidence of drinking problems in their family. This group was followed up a year and a half later to determine their situation. Twenty percent had another drinking-related charge. Measures of consumption and problem drinking remained about the same. The study concluded that many in the group had a drinking problem and that minor legal sanctions did not affect them.

-- Any rationalizations to minimize your substance use should alert you to the danger that you may have crossed the line into defensive thinking. You need to be aware of the importance of this. One of the first signs of substance abuse or dependency is justifying what would normally be unacceptable behavior. The simplest definition of substance abuse is continuing to use, even though your use is creating problems. You should openly and nondefensively examine your substance use and learn as much as possible from this program. Hopefully, you will make your decisions about future use based on fact, not on defensive or wishful thinking.

Another way to reduce student resistance is to separate the course from the Court and law enforcement in as many ways as possible. Make clear that the course has nothing to do with who is arrested or with what sentence they receive. Disassociate the course from punishment and emphasize its educational goals.

Attention to the details of program operations will add to the quality and effectiveness of the ADEP. Registering students and collecting fees should be done with a minimum of time and distraction. This is no place for sloppy practice and procedures. It is advisable to have adequate numbers of competent personnel to assist with procedural and organizational tasks.

Do not admit persons, whether students or parents, who are intoxicated or impaired to class. They can be disruptive, or they may "sleep it off" during the course and thus get credit for attendance while in reality wasting everyone's time. Course requirements should clearly point out the rule for student sobriety. The rule must be strictly enforced by instructors and other personnel. If a staff member suspects impairment but is not certain (for example, there is no smell of alcohol), he or she can focus on any subsequent, inappropriate behavior that may occur and then take action accordingly.

INTRODUCTION

ORIENTATION OF STUDENTS

Instructor Note: Initial introductions need to be made and students need to be oriented to class expectations.

- *Introduce self and any other staff.*
- *Welcome students. Each student may be asked to introduce himself.*
- *Inform students of class expectations and structure and requirements for successful completion.*

Topics which should be covered include:

- Class length
- Breaks and, if applicable, meals
- Location of restrooms, drinking water and snack machines, if available.
- Any rules regarding smoking
- Any rules regarding refreshments in class
- Punctuality in returning from breaks and starting new class sessions
- Telephone number to call if they have questions or a reason for not attending class
- Expectations regarding the participation of family members
- Payment of fees
- Confidentiality of information
- Students' respect for each others' confidentiality
- No substance use prior to or during class. Anyone violating this rule must be asked to leave.
- Complete all assignments and forms.
- Cooperate with ADEP staff and fellow students

The instructor should inform students of their rights and the grievance procedure to follow should they have a complaint about the program. Student rights include the right to be treated with respect and dignity, to have records kept confidential, to be free of physical and verbal abuse, and to not be denied services because of race, sex, creed, marital status, national origin, or handicap. The instructor should distribute the handout on page I-4 in Appendix I, if this has not been done earlier.

INITIAL PAPERWORK

Instructor Note: Complete all initial paperwork required by regulations including: (1) Student Registration; (2) Parent Involvement form; (3) Consent to Release Form; (4) Pre-test; and (5) Screening Questionnaire. (See Appendix I for copies of these forms.)

ADEP GOALS

The primary purpose of the course is to help you reevaluate your past decisions about alcohol or drug use by:

- Giving you clear, factual, objective information about alcohol and other drugs of abuse.
- Helping you examine your motivations for substance use and the consequences that your use may be creating.
- Recognizing warning signs of substance abuse and dependency and learning where help is available, if needed.

MAGNITUDE OF ADOLESCENT SUBSTANCE USE

The incidence of substance use/abuse increased throughout the 1960's, 1970's, and early 1980's. In more recent years, there has been a leveling off and even a decrease in the use of some substances. In the past ten years marijuana use by high school seniors within the past month has dropped nearly one third (from 32% to 23% of seniors). Daily use of marijuana has dropped even more dramatically (from 11% to 4%). The use of amphetamines, sedatives, and tranquilizers has been cut in half. In 1987 for the first time, cocaine use declined, dropping nearly one third (from 6.2% to 4.3% reporting "current use"). Alcohol use has remained relatively constant with 65 percent of high school seniors drinking in the past month. It is estimated that approximately 27,000 Missourians under the age of 18 need treatment for substance abuse (11,400 for alcohol, 15,600 for drugs).

Research indicates that the majority (56%) of youth in treatment began their problematic substance use before the age of 14. Six percent experienced their first problem use before they were ten years of age. The younger the individual is when substance use begins, the more likely he or she is to have later problems associated with that use. The likelihood of substance abuse problems in later years is reduced if the individual puts off initial use past adolescence.

Missouri arrest data for 1984 shows that there were 2,500 juvenile arrests specifically for alcohol and drug offenses. These figures do not include alcohol or substance involvement in curfew violations, loitering, disorderly conduct, vagrancy, or violent crime.

Alcohol and drugs are also considered to be a significant factor in suicide rates among all ages, but especially for the young. The suicide rate for 15-24 year olds has tripled in the last 30 years. The use and/or abuse of alcohol and drugs adds to a teenager's risk. Some studies indicate that as many as 50 percent of all suicide victims had used and/or abused substances, or that alcohol and/or drug abuse had been a family problem. A California report found that 25 percent of the 68 victims in their study were under the influence of drugs or alcohol at the time of their deaths, and that 48 percent of the population had family problems due to alcoholism and 16 percent due to drug abuse. A family history of alcohol and drug abuse may be considered a high risk. The Christian Science Monitor reports that nearly half of adolescent suicides involve alcohol or drug use shortly before death, while another study reports that 70 percent of all teen suicides had alcohol in their systems. The stresses that cause adolescents to use drugs and alcohol also contribute to their suicides.

Substance abuse is also a contributing factor in all types of accidents, acts of violence, and other crimes. For example, alcohol is involved in 70 percent of drowning accidents.

Traffic accidents are the number one killer of people under age 25. More 15-24 year olds die of alcohol related accidents than of any other cause. Teenagers account for 7 percent of licensed drivers but account for 12 percent of the alcohol-related fatal accidents. Teenagers have this high accident rate even though they average fewer miles per driver than other age groups.

In the United States, nearly 8,000 high school aged young people are killed each year in accidents involving alcohol. In 1984, almost 60 percent of fatally injured teen drivers were found to have alcohol in their bloodstream; 43 percent were legally intoxicated.

The Surgeon General has reported that life expectancy in the United States has improved over the past 75 years for every age group except the 15-24 year old group. This group has a higher death rate today than it had 20 years ago. Remember: alcohol is the leading cause of death in the 15-24 year old group.

"ABUSE AND LOSE" AND OTHER LAWS

Instructor Note: Distribute the graph on page III-1 in Appendix III to students or draw the graph on a blackboard or flipchart to illustrate the disproportionate number of youth involved in automobile accidents.

Such tragic statistics were the primary reason for the Abuse and Lose statute passed in 1987. The law is intended to discourage alcohol and drug use and to reduce the traffic deaths and injuries due to driving while drinking or drugging.

Instructor Note: The following information is taken from Revised Statutes of the State of Missouri (1986) and the1987 Supplement and may be technical in nature. This information is provided to you as an extensive resource. The instructor should summarize relevant information and answer student questions rather than recite the technical information in its entirety.

> **577.500. Revocation of driving privileges, persons under twenty-one years of age—violations of certain state laws—surrender of licenses—court shall forward order to department of revenue.**—1. A court of competent jurisdiction shall, upon a plea of guilty, conviction or finding of guilt, or, if the court is a juvenile court, upon a finding of fact that the offense was committed by a juvenile, enter an order revoking the driving privileges of any person determined to have committed one of the following offenses and who, at the time said offense was committed, was under twenty-one years of age:
>
> *There are five violations of state law which result in the loss of driving privileges for one year, if committed by a person under 21 years of age.*
>
> (1) Any alcohol related traffic offense in violation of the laws of this state;
>
> *Under this provision there are two basic charges: driving while intoxicated or drugged (577.010) and driving with excessive blood alcohol content (577.012). Conviction of a first offense for a DWI charge is a Class B misdemeanor. A Class B misdemeanor is punishable by imprisonment for up to six months and a fine of up to $2,000. Punishment also includes eight points against the drivers license for the first offense.*
>
> *Conviction of a first offense of an excessive BAC charge is a Class C misdemeanor punishable by a term of not more than 15 days in jail, a fine of not more than $300, and six points charged againt the drivers license.*
>
> (2) Any offense in violation of the laws of this state involving the possession or use of alcohol, committed while operating a motor vehicle.
>
> *Any minor in possession of alcohol (311.325) is also guilty of a misdemeanor.*

(3) Any offense involving the possession or use of a controlled substance as defined in chapter 195, RSMo, in violation of the laws of this state;

> *First offense in violation of laws pertaining to Schedule I or II drugs can result in imprisonment in a state facility for not more than 20 years or by imprisonment in a county jail for not less than six months or more than one year, except for possession of less than 35 grams of marijuana or less than 5 grams of hashish. Such a first offense of possessing small amounts of marijuana or hashish is a Class B misdemeanor and is punishable by not more than one year in a county jail and/or a fine of not more than $1,000 (plus attendance at an Alcohol and Drug Education Program).*
>
> *Other offenses involving Schedule I or II drugs range in seriousness and degree of punishment up to and including life imprisonment.*

(4) Any offense involving the alteration, modification or misrepresentation of an operator's or chauffeur's license in violation of section 311.328, RSMo.

> *Alteration of drivers license is a misdemeanor, punishable by a fine of not more than $1,000 and/or confinement of not more than one year (section 311.328 RSMo 1986).*

(5) Any offense in violation of state law involving the possession or use of alcohol for a second time; except that a determination of guilt or its equivalent shall have been made for the first offense and both offenses shall have been committed by the person when the person was under eighteen years of age.

> *Second offense of possession of alcohol by a minor (section 311.325 RSMo 1986) is a misdemeanor.*

2. The court shall require the surrender to it of all operator's and chauffeur's licenses then held by any person against whom a court has entered an order revoking driving privileges under subsection 1 of this section.

3. The court, if other than a juvenile court, shall forward to the director of revenue the order of revocation of driving privileges and any licenses acquired under subsection 2 of this section.

4. (1) The court, if a juvenile court, shall forward to the director of revenue the order of revocation of driving privileges and any licenses acquired under subsection 2 of this section for any person sixteen years of age or older, the provision of chapter 211, RSMo, to the contrary notwithstanding.

(2) The court, if a juvenile court, shall hold the order of revocation of driving privileges for any person less than sixteen years of age until thirty days before the person's sixteenth birthday, at which time the juvenile court shall forward to the director of revenue the order of revocation of driving privileges, the provision of chapter 211, RSMo, to the contrary notwithstanding.

577.505. Revocation of driving privileges, persons over twenty-one years of age—possession or use of drug in motor vehicle—surrender of licenses—court shall forward order to department of revenue.—A court of competent jurisdiction shall enter an order revoking the driving privileges of any person determined to have violated any state, county, or municipal law involving the possession or use of a controlled substance, as defined in chapter 195, RSMo, while operating a motor vehicle and who, at the time said offense was committed, was twenty-one years of age or older when the person pleads guilty, or is convicted or found guilty of such offense by the court. The court shall require the surrender to it of all operator's and chauffeur's licenses then held by such person. The court shall forward to the director of revenue the order of revocation of driving privileges and any licenses surrendered.

Driving privileges are lost for one year by any adult possessing or using a controlled substance while driving. This includes a state, county, or municipal charge.

577.510. Department of revenue to revoke license upon receipt of court order or sixteenth birthday—hardship driving privilege may be granted by court, procedure—temporary instruction permits may be issued by department of revenue.—1. Upon receipt of a court order revoking the driving privileges of a person pursuant to sections 577.500 and 577.505, the director of revenue shall revoke the driving privileges of such person for a period of one year, provided however, that in the case of a person who at the time of the offense was less than sixteen years of age, the one-year period of revocation shall commence on that person's sixteenth birthday. The provisions of chapter 302, RSMo, to the contrary notwithstanding, the revocation shall be imposed without further hearing. Any person whose driving privileges have been revoked pursuant to sections 577.500 and 577.505 may petition the circuit court for a hardship driving privilege and said application shall be determined and administered in the same manner as allowed in section 302.309, RSMo.

2. The director of revenue shall permit the issuance of a temporary instruction permit in the same manner as allowed in subsection 2 of section 302.130, RSMo, to persons fifteen years of age and under seventeen years of age denied driving privileges by court order pursuant to section 577.500. This exception only applies to instruction permits that entitle a person to operate a motor vehicle on the highways in the presence of an authorized instructor.

Hardship driving privileges may be obtained (except by those operating a vehicle under the influence of narcotic drugs or a controlled substance as defined in Chapter 195 RSMo).

Occasionally a person who has had his driver's license suspended or revoked is tempted to continue driving. Driving while revoked is a Class A misdemeanor with a penalty of 48 hours of consecutive imprisonment or ten days (40 hours) of community service.

Hardship driving permits may be obtained by those who have had their license suspended or revoked. A hardship driving permit allows the person to drive to school or work. A permit generally can be obtained unless the applicant has been convicted of a felony in which a motor vehicle was used, has been convicted of operating a motor vehicle under the influence of narcotic drugs or a controlled substance, or has left the scene of an accident. A person cannot receive a hardship permit if he has been granted a hardship driving permit in the five years preceeding the present application or has refused to take a chemical test to determine sobriety in the preceeding five years. (Refer to Section 302.309 RSMo)

577.515. Failure to surrender licenses, certain law enforcement officer may seize.—If a person shall neglect or refuse to surrender all operator's and chauffeur's licenses, as provided for in sections 577.500 and 577.505, the director shall direct the state highway patrol or any peace or police officer to secure possession thereof and return such license or licenses to the director.

577.520. License reinstatement, fee, when.—No person who has had his license revoked under the provisions of sections 577.500 and 577.505 shall have that license reinstated until he has paid a twenty-dollar reinstatement fee and has successfully completed an alcohol or drug related education program that meets or exceeds minimum standards established by the department of mental health. The responsibility for the cost of the program shall be borne by the person attending the program.

Completion of ADEP is one of the requirements for license reinstatement. A $20 reinstatement fee must also be paid.

577.525. Completion of alcohol or drug related education program, persons under twenty-one years of age, required, when, standards by department of mental health.—A court of competent jurisdiction shall enter an order, in addition to other orders authorized by law, requiring the completion of an alcohol related education program which meets or exceeds minimum standards established by the department of mental health, as part of the judgment entered in the case, for any person determined to have violated a state, county, or municipal law involving the possession or use of alcohol and who at the time of said offense was under twenty-one years of age when the court, if a juvenile court, finds that the offense was committed by such person or, if a city, county, or state court, when the person pleads guilty, or is convicted or found guilty of such offense by the court.

Completion of ADEP is required for those under age 21 with an offense involving possession or use of alcohol.

195.200. (a) For the first offense of possession of thirty-five grams or less of marihuana or five grams or less of hashish, such person shall be confined in the county jail for a term of not more than one year, or be fined not more than one thousand dollars, or be punished by both such confinement and fine. In addition to or in lieu of any punishment imposed under this paragraph, the court shall, except where the offender has also been convicted of a felony which arose out of the same incident or where the court determines that there is no suitable program reasonably available to the offender, require the offender to attend a drug education program certified by the department of mental health for such purpose. Failure to complete a drug education program as required by a court under this paragraph shall constitute contempt of court and shall be punishable by confinement in the county jail for not more than sixty days. Persons required to attend a drug education program pursuant to this paragraph may be charged a reasonable fee to cover the costs of such program. If the court requires the offender to attend a certified drug education program in lieu of any punishment, the requirement of attendance shall be a prior conviction and may be pleaded, heard, and determined as a prior conviction in any subsequent prosecution.

Completion of ADEP is required for those with a first offense of possession of small amounts of marijuana. Failure to do so can result in a 60 day jail sentence.

(b) For the second and subsequent offenses for the possession of marihuana or the first offense of possession of more than thirty-five grams of marihuana or more than five grams of hashish, any person, upon conviction, shall be imprisoned in a state correctional institution for a term of not more than five years, or be confined in the county jail for not more than one year, or be fined not more than one thousand dollars or be both confined and fined.

SUBSTANCES OF ABUSE AND THEIR EFFECTS

BASIC TERMS AND CONCEPTS

Drug: A non-food substance which, when introducted into the body, alters the way the body functions.

Psychoactive Drug: A drug that brings about a chemical action in the brain which affects and alters feelings, thinking or behavior.

For the purposes of this program, we will focus our attention on psychoactive substances which change how the individual feels. Some have limited legal uses (alcohol); some have medical uses (sedatives, tranquilizers); others are entirely illegal (marijuana and cocaine, or its derivative crack).

Psychological Dependence: A strongly felt need to use a substance repeatedly. The individual believes that he either performs better or needs the drug to perform at all.

Tolerance: The ability of the individual to accommodate more of the substance in order to achieve the same effect or feeling.

Physical Dependence: The body has become accustomed to the presence of the drug and reacts negatively, e.g. shakes, nausea, cramps, when the drug is withdrawn. Addiction is another term for physical dependence.

Potentiate: Interaction between two substances in which the combined effects of taking the two are far greater than may be expected. While all psychoactive substances interact when combined, the combination of some substances is much more unpredictable and toxic than others. It is as though the combined effect is greater than the sum of the two. Instead of one plus one equalling two, the combined effect is greater. The combination of alcohol with barbiturates, sedatives, or tranquilizers is among the most dangerous combinations.

Withdrawal: The feeling of discomfort experienced with the cessation of the substance. For some substances withdrawal is quite pronounced and in rare instances may be life threatening (i.e. barbiturates).

Substances: Alcohol or drugs or both.

Each psychoactive drug may have a somewhat different effect on the individual. For instance, marijuana makes some users act outgoing and talkative; other users become self-contained and quiet. Even the same user taking the same amount of a drug can react differently than he or she did before. Why? The psychoactive effects of a drug depend on four things:

1. **The Dose.** How much of the drug is being taken? How strong is the drug? It is very hard to tell the exact strength of a street drug. For example, marijuana comes from different countries and varies in THC content. LSD does not come in a standard dose.

   In fact, the use of illegal street drugs or pills may be referred to as "taking garbage". The user cannot be certain of the type of drug, its purity, or its dosage.

2. **The Person's Body.** Reactions to a drug may be different depending on how large or small a person is. It takes more alcohol for a large person to become drunk than for a small person. Food a person has eaten may slow down or speed up the effects of some drugs. Other qualities of the body can change how rapidly or how strongly a drug affects it.

   There may be a genetic or biological factor. Some people are allergic to some substances. One example of this is the reaction that many Orientals have to alcohol. Over one-third of Orientals become flushed and nauseous upon drinking alcohol.

   If someone has used a drug regularly, his or her body may require more of the drug to produce the desired effect. Very experienced users may be able to take a dose of some drugs that would kill an inexperienced user or cause the person to become very ill.

3. **The Route.** How is the drug being taken? A drug can be swallowed, inhaled, or injected. The quicker it gets into the bloodstream, the quicker it gets to the brain and the nervous system to produce its effects.

   The quickest way into the bloodstream is by injection—the drug is injected directly into a vein with a needle. Inhaling is also relatively quick. The drug enters the bloodstream through the thin blood vessels of the nose or the lungs. When a drug is swallowed, it is absorbed into the bloodstream through the walls of the stomach or small intestine. This is the slowest method for the effects to be felt.

4. **Set and Setting.** Someone who tries a drug usually has a number of ideas as to what is going to happen. This is called a mind set. These ideas are usually based on what the

person has heard or read, previous experiences with drugs, and the mood the person is in. The setting or environment in which the drug is taken also affects what happens.

Psychoactive substances have both short-term and long-term effects. Short-term effects are those that appear immediately or soon after use. Some short-term effects are noticeable to the user or those around him. For example, a person who uses marijuana may notice irritation to the throat or lungs, increased hunger, slight changes in sensory perceptions and the feeling of time passing more slowly. Those around the user may notice bloodshot eyes, becoming more giddy or withdrawn, or difficulty concentrating and keeping a train of thought. Some short-term effects on the body may not be noticeable to either the user or others. For example, heart beat increases and reaction time is impaired. (See page III-3 in Appendix III for further information regarding the physical effects of drugs of abuse.)

Long-term effects of psychoactive substances are generally more difficult to detect and can be more serious in nature. These serious effects gradually accumulate. Change from week to week is not noticeable. For example, marijuana use can eventually affect hormones related to sexual development. Boys can develop reduced sperm count and slightly feminine characteristics, such as increased fat in the chest/breast area. Reduced motivation and energy level often results from long-term use. These gradual changes may be hard to notice and, if they are noticed, will not usually be attributed to marijuana use. The specific short-term and long-term effects will vary from one psychoactive drug to another, but the general principle applies to all substance use.

Psychoactive drugs are typically classified by the effect they produce. We are going to review the basic psychological and physical effects of drugs beginning with alcohol and tobacco and continuing through marijuana, stimulants, sedatives, hallucinogens, narcotics and inhalants.

ALCOHOL

Alcohol is a sedative drug which slows down the activity of the brain, even though most people claim they feel alert and energetic after a few drinks. The alcohol that a person drinks is carried throughout the body by the blood stream. Alcohol affects all parts of the body which it touches, and it touches virtually all parts of the body. The greater the concentration of alcohol in the blood, the more alcohol that is carried to the brain.

Alcohol affects the brain in stages. First affected is the cerebrum, which controls the person's judgement, thinking, and inhibitions. The cerebellum is later affected, resulting in impaired vision, speech, reactions, and muscular coordination. If the individual continues to drink, eventually that part of the brain which regulates the body's autonomic functions (breathing, heartbeat, digestive process) becomes impaired. At high doses, alcohol can cause coma and death.

Alcohol is alcohol. There is approximately the same amount of alcohol in 12 ounces of 5% beer, a 5 ounce glass of 12% wine, and a 1-1/4 ounce of 86 proof (43%) whiskey. Alcohol that is consumed is ethyl alcohol. Its chemical formula is C_2H_5OH. It is very close in composition to ether $(C_2H_5)_2O$. If two molecules of alcohol were combined C_2H_5OH + C_2H_5OH and a molecule of water H_2O were removed, that which remained would be ether. Not surprisingly, alcohol has historically been used as a pain killer and sedative before more modern and effective medical advances have made any sedative use of alcohol obsolete.

Blood alcohol content is determined by three things: body weight, amount of alcohol consumed, and the time taken to consume it. The larger the individual, the more blood there will be to dilute the alcohol. Larger people usually are able to drink more alcohol because of this.

Alcohol is eliminated from the system almost entirely by the liver. The liver oxidizes the alcohol at a fairly constant rate. For most healthy adults, this rate is approximately three quarters to one ounce of alcohol per hour. Since the liver operates at a constant rate, all attempts to speed up the process (cold showers, black coffee, exercise, food, etc.) are futile.

Alcohol is a sedative or depressant. It depresses the functions of the brain, making the person who drinks it feel better and perform worse. Not only do they perform worse, they tend not to recall how poorly they drove, danced, talked, or behaved in general. The user remembers more clearly how they felt and they remember feeling good. In their own mind, they may think that if they felt good they must have performed well and acted well, or at least have been entertaining.

A person can develop a strong psychological and physical dependence on alcohol. Drinking for some people is a way to relax, have a good time, or to escape emotional problems, pressures, and decision-making. Over a period of time with heavy or regular use, the body develops a tolerance to alcohol. That means the person needs more and more alcohol to achieve the same effect. In some cases physical dependence occurs. When the person cannot get alcohol, withdrawal symptoms occur such as shakiness, sweating, vomiting, diarrhea, headaches, agitation, and sleeplessness. In severe cases, delirium tremors may occur.

Alcohol is a toxic chemical and its consumption can cause any number of physical, emotional, and psychological problems. Alcohol use is involved in 25-50 percent of all hospital admissions. Alcoholism shortens a person's life span by an average of 12 years. One quarter of those with alcohol problems die before the age of 50.

Alcoholism is a serious problem. At least one out of every ten Americans who drink will become alcoholic. There are more than ten million alcoholics in this country. One out of every five drinkers will develop significant problems related to their alcohol use.

Teenagers can have drinking problems despite their youth. In fact, alcohol abuse is the number one drug problem of American teenagers. At some point in growing up, alcohol becomes an "in" thing among many groups. Some friends will begin to drink alcohol regularly and this can prompt you to do the same. Studies indicate that the most important factor influencing your use of alcohol or other drugs is whether or not your friends use and offer you alcohol or drugs. Parents' influence is much less, although by no means unimportant. Beer is the favorite drink of teenagers. This is no surprise, considering that you have seen approximately 100,000 beer commercials by the age of 18.

FETAL ALCOHOL SYNDROME

Fetal Alcohol Syndrome (FAS) is a pattern of mental and physical defects which may develop in an unborn baby when the mother drinks alcohol during pregnancy. A baby born with FAS may be seriously handicapped and require a lifetime of special care. Less severe defects, such as small body size and lower birth weight, are called Fetal Alcohol Effects (FAE) or Alcohol-Related Birth Defects (ARBD).

Any alcohol intake during pregnancy can potentially damage a developing fetus. Fetal Alcohol Syndrome and its less severe manifestations, ARBD, are the largest single class of birth defects that are 100 percent preventable. A diagnosis of FAS involves marked deficiency in all three of the following categories: growth, brain function and facial characteristics. When a child has a marked deficiency in one or two of these areas (and maternal alcohol use or binge drinking is confirmed), then the terms ARBD or FAE are utilized.

FAS symptoms can include:

- Growth deficiencies: small body size and weight, slower than normal development and failure to catch up.
- Skeletal deformities: deformed ribs and sternum; curved spine; hip dislocations; bent, fused, webbed, or missing fingers or toes; limited movement of joints; small head.
- Facial abnormalities: small eye openings; skin webbing between eyes and base of nose; drooping eyelids; nearsightedness; failure of eyes to move in same direction; short upturned nose; sunken nasal bridge; flat or absent groove between nose and upper lip; thin upper lip; opening in roof of mouth; small jaw; low-set or poorly formed ears.

- Organ deformities: heart defects; heart murmurs; genital malformations; kidney and urinary defects.

- Central nervous system handicaps: small brain; faulty arrangement of brain cells and connective tissue; mental retardations—usually mild to moderate but occasionally severe; learning disabilities; short attention span; irritability in infancy; hyperactivity in childhood; poor body, hand, and finger coordination.

Any woman who hopes to give birth to a healthy baby must be concerned about Fetal Alcohol Syndrome. These effects of alcohol on a growing fetus are the result of the fact that alcohol circulates throughout the body, including the placenta. A developing embryo cannot break down the alcohol as rapidly or as effectively as the mother's system and thus the effects of alcohol are more damaging.

Although alcohol consumption at any time during pregnancy is potentially harmful to the fetus, timing and duration of exposure can be related to the type of damage likely to occur. Early exposure presents the greatest risk for serious physical defects, and later exposure increases the chances of neurological and growth deficiencies or miscarriage.

The first trimester is the most critical time when structural and abnormal features can occur. One alcohol effect during the second trimester includes a major risk of miscarriage. In the last trimester, alcohol can impair the rapid and substantial growth of the fetus. Neurological functions are at risk also, as this is the period of greatest brain development.

One case of FAS occurs in approximately every 1,000 births. This results in approximately 4,000 FAS births per year in the United States and approximately 60 in Missouri. Full FAS occurs in at least 2.5 percent of pregnancies in which the mother is a problem drinker. The occurrence of ARBD is as much as 20 times higher than FAS. Approximately 50 to 70 percent of women with alcohol problems have children with ARBD.

A study of children of alcoholic mothers found IQ scores 10 to 19 points lower than controls, as well as retarded development of hearing and speech, eye-hand coordination, concept formation, and practical reasoning. Hyperactivity and short attention span occur more often in the children of alcoholic mothers.

A 10-year follow-up study of adolescents who were born with the Fetal Alcohol Syndrome indicates that its effects are permanent. The correlation between severity of mental retardation and severity of physical deformity and growth deficiency has persisted into adolescence. Although good quality of home life is associated with improved social and emotional development in these children, it does not overcome the severe handicaps caused by heavy prenatal alcohol exposure.

Studies suggest that drinking a large amount of alcohol at any one time may be more dangerous to the fetus than drinking small amounts more frequently. A safe amount of drinking during pregnancy has not been determined, and all health authorities agree that women should not drink at all during pregnancy. Unfortunately, women sometimes wait until a pregnancy is confirmed before they stop drinking. By then, the embryo has gone through several weeks of critical development, a period during which exposure to alcohol can be quite damaging. Women who are pregnant or anticipating a pregnancy should abstain from drinking alcoholic beverages. But this can be difficult. With various media messages depicting alcohol in a positive way and social pressure to drink, it can be difficult to avoid alcohol. The first step is to realize the dangers of drinking during pregnancy and to realize the social pressures to use alcohol. To assure a healthy baby, a mother must find a way to avoid alcohol in her own life.

The father can share in this responsibility by supporting the mother's decision not to drink alcohol during the pregnancy. This will help prevent a disability in his child, and he will share the responsibility of giving his baby the best possible start.

BLOOD ALCOHOL CONCENTRATION (BAC)

Alcohol is alcohol and is chemically the same whether it is in beer, wine, or distilled spirits, such as whiskey, vodka, gin, or rum. Most servings of alcoholic beverages contain the same amount of alcohol, e.g. a 12 oz. can of 5% beer contains approximately .6 oz. of pure alcohol; a 5 oz. glass of 12% wine also has .6 oz of alcohol; a 12 oz.bottle of 5% wine cooler contains approximately .6 oz. of alcohol; and a mixed drink with 1 1/4 oz. of 86 proof (43%) whiskey contains .6 oz of alcohol.

A person's blood alcohol concentration (BAC) is determined by three things: body weight, amount of alcohol consumed, and the time taken to consume it. BAC is expressed as a ratio of weight to volume. BAC is the number of grams of alcohol per 100 milliliters of blood. Scientists and the courts generally have agreed that a ratio of 2,100-to-1 can be used as the approximate ratio between blood alcohol concentration and deep-lung breath alcohol concentration. That is, the concentration of alcohol in the blood is approximately 2,100 times the concentration of alcohol in deep-lung breath. This is a conservative figure—with most individuals, the blood alcohol concentration is more than 2,100 times greater than the breath alcohol concentration. By determining the alcohol concentration in a sample of a person's deep-lung breath, a breath analyzer can compute the concentration of alcohol in the person's bloodstream. Blood alcohol content can also be determined from samples of blood and urine.

The volume of blood in the body of the drinker is very important because it determines how much the alcohol will be diluted when it enters the bloodstream. The larger volume of blood, the lower will be a person's BAC when consuming a drink. One's volume of blood can be estimated based on body size. Generally, a heavier person has more blood than a smaller person.

A large person can drink the same amount during the same time as a smaller person and yet will have a lower BAC. Sometimes people in a group believe they should consume drink-for-drink with each other. This can be disastrous for some, especially those who are smaller or less muscular. Muscle tissue has more blood than does fatty tissue so an obese person, although he might weigh more than a smaller more muscular person, might have less blood to dilute the alcohol. Therefore, the heavier but more obese person could have a higher BAC. Also, women tend to have higher fat to muscle ratios than men. Consequently, they will tend to have higher BAC's than would a male of the same weight who drank the same amount of alcohol in the same amount of time. However, the fat-to-muscle ratio is not as important as body weight, amount of alcohol, and time.

Carbonated beverages tend to enter the small intestines faster and are absorbed more quickly there. Because most alcohol enters the body through the small intestines, drinks which are bubbly will enter the blood stream faster than those which are not. However, this should have a fairly negligible effect over the course of an evening or several hours of drinking.

Rapid drinking results in a higher blood alcohol concentration than does slower drinking. Someone who drinks a large amount over a period of hours may consume much more total volume of alcohol but have a lower BAC than someone who drinks a smaller amount in a short period of time.

The liver eliminates (oxidizes) alcohol at a fairly constant rate for almost all people. Some variations occur as a result of general health, damage to the liver, age of the drinker, plus other considerations. The liver eliminates approximately one drink per hour (one beer, one glass of wine, one wine cooler, one mixed drink). Thus, it is possible to calculate how much alcohol was consumed in a particular period of time by someone whose body weight is known and then to predict the person's BAC.

(OPTIONAL) PHYSICAL SIGNS AND APPROXIMATE BAC

- BAC under .05%
  - -- Flushed cheeks
  - -- Warm feeling
  - -- Talkative
  - -- Reduced inhibitions
  - -- Lightheadedness
  - -- Exhilaration
  - -- At .03%, all people show impairment of reaction time.
  - -- At .04%, many people show impairment of vision.
- BAC .05% - .10%
  - -- Dulled perceptions
  - -- Judgement probably impaired
  - -- Argumentative
  - -- Tired
  - -- At .05%, judgement and inhibition are noticeably affected
  - -- At .05%, field of vision is reduced 30%
  - -- At .08%, visual acuity, night vision, and ability to focus are impaired
- BAC .10% - .15%
  - -- Poor coordination
  - -- Poor space and time perception
  - -- Poor decision making

-- Impairment of depth perception and peripheral vision

-- Antisocial behavior (extreme agressiveness while driving, following too closely, running red lights, only slowing for stop signs, any behavior which tends to disregard the rights and safety of others)

--Sleepiness

-- Depression

-- At .10%, all people show definite impairment of reaction time, judgement, vision, and muscle control (balance, coordination, and stability). Most people show impairment of these capabilities below .10%. The legal limit of intoxication while driving is .10% in Missouri, as well as most states.

-- At .12%, the distance one can see is reduced 20%

- BAC .15% - .25%

-- At .20%, loss of emotional control

--Unconsciousness may occur

- BAC .25% - .40%

-- At .30%, recognition of situations and objects is impaired

-- At .35%, impairment of awareness of time and place is evident.

-- Convulsions, vomiting and coma may occur.

- BAC over .40%

-- Death may occur. Half of the people who accumulate a BAC of .40% will die.

Instructor Note: (Optional) Provide examples of how body weight, amount of alcohol, and time influence BAC. Several students may be asked about their drinking offense and a BAC approximation determined by the instructor. (See page III-6 in Appendix III for a BAC chart.)

DRINKING MYTHS

Many drinkers, both new and experienced, have some very common but erroneous concepts about alcohol, drinking and how to sober up. (See page III-7 in Appendix III for a list of these myths.)

Instructor Note: Ask the class to brainstorm the commonly attempted methods for sobering up faster. Ask if any of these techniques are successful. Clarify the fallacies of each method. Be sure the discussion includes: coffee, fresh air, cold showers, and exercise.

- A shower results in a wet drunk. Exercise results in a tired drunk. Coffee results in an awake drunk. Sobering up results from the body reducing its blood alcohol concentration. This is mainly accomplished by the liver oxidizing the alcohol. Ninety percent of alcohol is broken down in the liver. The remaining 10 percent is directly eliminated through breath, sweat, and urine. Since the liver oxidizes alcohol at a constant rate, only time can sober up the intoxicated person. Therefore, none of the supposed "remedies" will have an effect. Long-term alcohol abuse causes liver damage, which slows the oxidizing process.

TOBACCO

Nicotine, one of the ingredients in tobacco, is a highly addictive substance. Over half of those who experiment with smoking tobacco become physically dependent on nicotine. Once addicted it is difficult to stop. Tobacco use is so widespread that some people either forget or choose not to accept that nicotine (either through smoking, dipping or chewing) is a mild psychoactive drug that is physically addicting. Nicotine is a stimulant which may produce a mild sense of well-being, especially after one has become accustomed to it. There are immediate physical reactions to smoking tobacco. The smoker's mouth, tongue, throat, and lungs become irritated. Appetite can decline and breathing can become difficult.

Smoking is the single largest preventable cause of premature death and disability in the United States. Smoking is related to 320,000 deaths a year, including 30 percent of all cancer deaths. Cigarettes cause 80 percent of the nearly 150,000 deaths due to lung cancer every year in the United States. Approximately 35 percent of smokers die prematurely because of tobacco. Smoking is one, if not the leading, cause of heart attacks. If smoking is continued after the attack, chances of survival are much poorer. Smoking accelerates pulse rate and constricts blood vessels, placing a strain on the heart. Tobacco smoke contains nicotine which acts on the heart, blood vessels, digestive tract, kidneys, and nervous system.

Emphysema is more common among smokers than nonsmokers. Women who smoke during pregnancy run greater risk of having smaller babies or even of babies born dead than women who do not smoke. Tobacco contributes to cancer of the mouth, tongue, lips, throat, lungs and to heart disease. Used in combination with alcohol, the effects are multiplied; the incidence of oral cancer is greater among those who drink and smoke than it is for those who do neither, or who only smoke or drink. One study has shown that alcohol consumption and heavy smoking produced up to fifteenfold increase in the rate of oral cancer, compared to those who neither drank nor smoked. Heavy smoking alone increased the risk only twofold to threefold.

MARIJUANA

After alcohol and tobacco, marijuana is the most widely used psychoactive substance in our country and state. The scientific name for marijuana is cannabis sativa, and it grows wild throughout most of the tropic and temperate regions of the world. This plant has long been cultivated for the tough fiber of the stem (used in making rope), the seed (used in feed mixtures), and the oil (used as an ingredient of paint), as well as for its psychoactive properties. The psychoactive ingredient in marijuana is THC, or more accurately delta 9 tetrahydrocannibanol.

Marijuana was a major cash crop in the early history of the United States. It was grown for use in making rope from the tough fiber (hemp) in the stalk of the plant. There are large amounts of wild marijuana growing in the United States but most wild stands contain little of the psychoactive ingredient.

Marijuana is usually smoked in the form of loosely rolled cigarettes. It may be taken orally (eaten), but is approximately three times more potent when smoked. The effects from smoking are felt within minutes, reach their peak in 10 to 30 minutes, and may noticeably linger for two or three hours. A condensed description of these effects is apt to be inadequate or even misleading, because the effects depend so much upon the experience and expectations of the individual as well as the potency of the drug itself.

Low doses tend to produce a sense of well-being, a dreamy state of relaxation, and frequently hunger, especially a craving for sweets. There are slight changes in sensory perception. The user may experience a more vivid sense of sight, smell, touch, and hearing. No scientific evidence indicates that marijuana improves eyesight, smell, touch, or hearing. Although the user may consider himself more insightful or knowledgeable, memory and concentration are actually impaired. It is difficult to keep a train of thought. Thoughts tend to be dreamy, unrelated, and fragmented. Time seems to pass more slowly. This state of intoxication may not be noticeable to an observer.

Some users become talkative and giddy; others become anxious and uncomfortable. Increased anxiety or even panic is the most commonly reported unpleasant effect of marijuana. Immediate physical effects of marijuana include a faster heartbeat and pulse rate, bloodshot eyes, and a dry mouth and throat. Heart rate increases as much as 50 percent. Studies of marijuana's mental effects show that the drug can impair short-term memory, alter sense of time, and reduce ability to do things which require concentration, swift reactions, and coordination, such as driving a car or operating machinery. High doses of marijuana may cause image distortions and mild hallucinations. Surroundings and people may seem strange or unreal.

When marijuana is smoked, THC, its active ingredient, is absorbed by most tissues and organs in the body; however, it is primarily found in fat tissues. THC is a fat soluble chemical (unlike alcohol which is water soluble) and thus tends to accumulate in the fatty linings in the cells of the body and the brain. Because the brain has a high level of fat, the brain is one of the major sites where THC accumulates. THC attaches to the fatty cell lining and is elminated from the body at a much slower rate than alcohol. The body, in its attempt to rid itself of the foreign chemical THC, chemically transforms it into metabolites which can remain in the body for a month to a month and a half after smoking marijuana. Someone who smokes one or two marijuana cigarettes a week is never free of the drug. For heavy users, the chemicals build up. Someone who smokes every day probably has ten times as much THC in his body as someone who rarely smokes.

A decade ago marijuana use was thought to be relatively harmless in both its short term and long term effects. However, with more scientific study, marijuana is known to pose some threat to physical health and psychological well-being, particularly with regular, long-term use.

The risks asociated with marijuana have also increased because the potency of marijuana on the streets is two or three times greater than a decade ago.

Broad scientific research on marijuana began only within the past ten to fifteen years, and it will probably take many more years to find the answers to all questions about the effects of marijuana on health. Those who insist on using marijuana are making themselves human guinea pigs in determining the long term consequences of the drug. Findings from completed studies show that:

- Smoking marijuana does not mix with school work. Marijuana makes learning more difficult because it interferes with concentration and thinking. It affects both verbal and math abilities. Memory is impaired and the sense of time is altered. Research shows that students do not remember as well what they have learned when they are "high". In addition, when young people start using marijuana regularly, they often lose interest and are not motivated to do their schoolwork, learn, and study.

- Marijuana harms the lungs in ways similar to tobacco. Marijuana can be especially harmful to the lungs because users often inhale the unfiltered smoke deeply and hold it in their lungs as long as possible. Therefore, the smoke is in contact with lung tissues for long periods of time, which irritates the lungs and causes maximum damage.

  A 1987 study determined that smoking a joint results in four times more tar deposited in the lungs than does smoking a cigarette. In addition, many marijuana users also smoke cigarettes; the combined effects of smoking these two substances creates an increased health risk.

  The marijuana plant contains over 400 chemicals in addition to the psychoactive ingredient THC. When marijuana is burned and smoked, over 2,000 chemicals result. Marijuana smoke has been found to contain more cancer-causing agents than tobacco smoke. Compared to tobacco, marijuana smoke has 50 percent more of the cancer causing chemicals benzpyrene and benzanthracene. Examination of human lung tissue that had been exposed to marijuana smoke over a long period of time in a laboratory showed cellular changes called metaplasia that are considered precancerous. In laboratory tests, the tars from marijuana smoke have produced tumors when applied to animal skin. These studies suggest that it is likely that marijuana may cause cancer if used for a number of years.

- Smoking marijuana can retard emotional development. Marijuana affects thinking and decision making and alters feelings. Young people become emotionally mature by learning how to make decisions, how to handle success, how to cope with failure, and how to form their own opinions and values. Young people who continually escape these "growing pains" by smoking marijuana are losing their opportunities to learn to be responsible, mature adults.

- Smoking marijuana seems to bring out mental problems or even worsen them. Long-term regular users of marijuana may become psychologically dependent. They may have a hard time limiting their use; they may need more of the drug to get the same effect; and they may develop problems with their jobs and personal relationships. The drug can become the most important aspect of their lives.

- Smoking marijuana can result in a loss of energy and motivation.

  "Burnout" is a term first used by marijuana smokers themselves to describe the effect of prolonged use. Young people who smoke marijuana heavily over long periods of time can become dull, slow moving, and inattentive. This phenomenon is sometimes called the "marijuana syndrome" or "amotivational syndrome".

- Many of marijuana's effects on a growing body are still unknown, but studies indicate a reduction in certain body chemicals (hormones) that can affect physical and sexual development.

  Studies of men and women who use marijuana have shown that marijuana can influence levels of some hormones relating to sexuality. These findings suggest that marijuana may be especially harmful during adolescence, a period of rapid physical and sexual development.

  Marijuana reduces the level of testosterone in males. Testosterone is the hormone which physically transforms young boys into men. It solidifies muscles, enlarges bone structure, produces rapid weight and height gains and causes genital enlargement. Anything which interferes with the production or level of testosterone has an adverse effect on all of these processes. After smoking one joint, the testosterone level drops 30 percent within three hours. Within 12 hours, the hormone returns to its normal level. If more than one joint is smoked, the hormone level stays down for a longer time than 12 hours. Heavy marijuana smoking for one month results in a testosterone level that is lowered at all times. However, this effect is not permanent; the body can recover.

LH is another hormone that affects physical and sexual development in both males and females. When a boy smokes marijuana, his LH supply takes a temporary nosedive similar to testosterone. However, the LH drop is even greater. Again it takes approximately 12 hours for the body to recover from a single dose.

Research also indicates that heavy marijuana use can result in reduced sperm count and sperm motility and in an increase of abnormal sperm. In one study, sperm count dropped 50 percent in men who used pot heavily for one month. In a few cases, adolescent males who regularly use marijuana develop an unusual hormone balance that results in enlarged breasts.

One study conducted on the influence of marijuana on male sexual functioning involved 40 participants between the ages of 18 and 28. Half used no marijuana during the study. The other half smoked one joint per day for at least six weeks. The male hormone, testosterone, was reduced 45 percent among the users. One-third of the marijuana users had a highly reduced sperm count.

Women can also suffer significant problems with their sexual and physical functioning due to marijuana. Menstrual cycles can become irregular, and ovulation (release of eggs) is disrupted. Changes in hormones somtimes causes or aggravates acne in adolescent girls. They may also develop more hair on their face, chest, and arms. The adolescent may have reduced fat deposits on hips, buttocks, breasts, or upper arms, thus making her appear less feminine.

There are fewer scientific studies on women than men. The United States government forbids the long-term testing of marijuana's effects on women because such tests potentially might harm a women's child-producing egg cells. A female is born with less than a half-million egg cells, and she never makes another. Starting at puberty, one egg is released each month. If a damaged egg cell is released and fertilized, a damaged baby can result The fact that women do not make new egg cells is the reason that pot tests on women are severely restricted by the United States Government. Men, on the other hand, produce millions of sperm cells each day. Although scientists are not 100 percent certain, it is believed that any damage to sperm cells is halted when smoking is stopped. There has been less research on women, but there still is clear scientific information, some of it from studies with monkeys.

Experiments with female rhesus monkeys, which have a hormonal and menstrual cycle similar to humans, indicate interference with normal ovulation. Monkeys skip one or more menstrual cycles when they are given the equivalent of four marijuana joints per week.

> The two hormones LH and FSH play an important role in regulating a female's menstrual cycle. Remember that the LH hormone level in males drops 50 percent after smoking one joint and takes 12 hours to return to normal. The LH pattern in studies of female rhesus monkeys shows exactly the same pattern.
>
> A study has been conducted comparing women between the ages of 18 and 30, half of whom had never used marijuana and half who used marijuana an average of four days a week. The marijuana users had three times as many menstrual irregularities. The women using had a lower level of female hormone (progesterone) and a higher level of male hormone (testosterone).
>
> Research studies suggest that the use of marijuana during pregnancy can result in premature babies and low birth weight. Marijuana seems to interfere with the passage of nutrients from the mother across the placenta to the fetus. Infant mortality rates increase with marijuana use. A breast feeding mother may have reduced milk production and may transfer THC to her baby through the milk that is available. These findings have been confirmed in studies of monkeys. When rhesus monkeys are given the human equivalent of one to two joints per day, they have five times as many miscarriages, still births, and infant death soon after birth. The infants that survived were lower in weight, had more illnesses, and were often hyperactive.

Tolerance does occur to marijuana's effects. Tolerance is a physical process in which more and more of the drug is needed to get the same effect. Tolerance to marijuana was first discovered in studies of hashish users in Europe and Asia who could use the equivalent of 50 potent reefers a day. A group of hashish smokers who had used for over 20 years had their brain waves compared to a group of occasional marijuana users. The long-term users required four to ten times as much THC as the occasional users to make their brain waves look stoned. Heavy, long-term users show striking tolerance to THC, and their bodies need far greater doses to get high. However, it does not take 20 years to develop tolerance.

Tolerance can develop within a few months, or a few years, depending on the frequency and quantity of THC used. Tolerance is more common among those who smoke several joints a day or those who use the more potent forms of THC, such as hashish. When marijuana is discontinued for a period of time, the body recovers and tolerance subsides.

Of course, most regular users would prefer to say that they can "handle more" rather than to say that they have developed tolerance and "need more" to get high. It means the same thing. The user's insistence that he is actually in better control is one form of denying the problem.

With many types of substances, tolerance is a major step toward physical addiction, with withdrawal symptoms occurring when the substance is not available. The answer to whether or not marijuana is physically addictive cannot be definitively answered at this time. At least one study has reported withdrawal symptoms lasting three to four days. The group of users had used marijuana for several years and, during the one month period of the study, had smoked ten joints a day. Their withdrawal symptoms included sweating, irritability, insomnia, weight loss, and brain wave changes.

Any withdrawal symptoms from THC may be disguised or minimized by the fact that THC stays in the body for such a long time. Small amounts of THC can be found in the blood for several weeks after smoking a joint. So even though a person may no longer be using, THC is still present in the body and is only gradually eliminated.

Whether or not there is a physical basis for coming to "crave" marijuana, it is quite clear that once someone becomes accustomed to marijuana, they are very reluctant to do without it. Some go to great lengths to acquire a continuing supply. Such drug-seeking behavior often goes along with dependence on a substance. (See pages III-10 through III-13 in Appendix III for further information regarding the effects of marijuana on the body.)

COCAINE

The coca plant has been known for 5,000 years to natives in South America, who have chewed the leaves to obtain low doses of the psychoactive drug. Cocaine is a processed extract of the coca plant. Cocaine is up to 100 times as potent as the level of cocaine obtained through ancient Indian custom of chewing the leaves of the plant. Until recently, cocaine was viewed as a "glamour drug" in this country because of its high price and, as a result, its use by the well-to-do. Processed cocaine in white powder form continues to remain fairly expensive. It is estimated that one-fourth to one-eighth of purchased cocaine actually consists of adulterants, such as sugar or quinine.

In the late 1970's "freebasing" (smoking rock like chunks of cocaine called "crack") lowered the unit price of cocaine and increased its availability. Freebasing produces a much quicker, more dramatic altered state than does the more traditional snorting. Smoking crack produces effects within seconds but they last only five minutes or so. Then the user has a "down" or "crashes". Crack requires ever more frequent doses and increased amounts to avoid the post use let down. Using crack shortens the time between first use and problematic use. Cocaine is addictive and can cause extreme physical and psychological problems.

All forms of cocaine use pose potential harm to the user. The problems presented by the use of crack are even more harmful. Because the effects of crack are so short-lived, the user is forced into a frequent use pattern which becomes financially draining and emotionally destructive. The abuser can experience profound depression and malaise when deprived of the drug.

The cocaine high involves a sense of well-being and energy. The immediate physical effects are to constrict blood vessels, increase heart rate and blood pressure, increase body temperature, and enlarge the pupils. Physical consequences of continued cocaine use can include insomnia, chronic fatigue, malnourishment, dehydration, severe headaches, nasal problems (if inhaled), respiratory problems (if smoked), poor or decreased sexual performance, seizures, and loss of consciousness. Cocaine use can also cause angina and irregular heartbeat. It can worsen preexisting heart disease and can bring on a heart attack. The most common causes of death from cocaine abuse are heart rhythm disturbances, heart failure, respiratory paralysis, and repeated convulsions. Death comes swiftly with few or no preceeding symptoms. A user will typically collapse into grand mal convulsions followed by a brief period of respiratory collapse and death.

Drug reactions can be as diverse as the people taking them. The drug which some take with seeming impunity can cause severe reactions and even death to another. Len Bias, a healthy and promising young basketball star from Maryland, chose to celebrate signing a lucrative professional contract by taking cocaine, reportedly for the first time in his life, and died as a result. Len Bias was famous and consequently what happened to him was publicized in all the news media. However, 14,000 cocaine users in the United States were rushed to the hospital emergency room during 1985. Of those, nearly 700 died. The number of cocaine deaths doubled in the period 1982-1985. The number of emergency room visits due to cocaine nearly doubled between 1985 and 1986 from 14,000 to 25,000.

STIMULANTS

Stimulants are drugs that increase activity and energy level by speeding up the body's processes. In addition to cocaine, amphetamines are the most common stimulant. Street names for amphetamines include bennies, dexies, speed and uppers. Amphetamines once were commonly used for dieting because they reduce appetite. They are used illicitly for a variety of reasons, usually to heighten physical energy or to stay awake and be able to function in school or on the job. Amphetamine use can lead to psychological dependence, with the user feeling unable to function without the drug.

Amphetamines tend to make users feel that they can achieve more than usual or go for extended periods without rest. The body, however, is not prepared for these expectations, so as the "up" feeling fades, the body may react with extreme fatigue. To prevent "crashing" (coming down from the drug) or to "maintain," the user will take more amphetamines. This coupled with tolerance (need for increased dosage to achieve the desired effect) can lead to physical dependence. Extreme discomfort can result when the drug is not available, and continued use is hard on the body, especially to the heart and vascular systems. The stress placed on the system caused by an ever increasing need for more frequent, larger doses can be dangerous. To intensify the effects of the amphetamines, some "speed freaks" liquify and inject the drug. Shooting amphetamines is one of the most dangerous forms of drug abuse. It can cause paranoia in the user and often leads to unprovoked violence. IV amphetamine use may cause paranoid schizophrenia, a very severe form of mental illness.

SEDATIVES

Sedatives relax the body's muscles, relieve feelings of tension and worry, and bring on sleep. There are two main groups of sedatives: barbiturates and tranquilizers.

Since the turn of the century, doctors have been prescribing barbiturates to patients so they can fall asleep and stay asleep. It was soon found that taking smaller doses of barbiturates brought about feelings of drowsy relaxation while still awake. These feelings are similar to those produced by alcohol.

Because barbiturates produce pleasant feelings, they are often used by people who do not need them, and barbiturates are often overused by people who are prescribed them. Overdose with barbiturates is quite possible. If it takes one pill to produce sleep, it might take five pills to produce a coma and only ten pills to cause death. This is a narrow range of safe use. Safety is complicated by the fact that alcohol can multiply the effects of barbiturates.

An intoxicated "down head" acts like a drunk. He or she slurs words and has trouble with simple physical movements, like walking. This person may suddenly become sleepy and "nod-off".

Many abusers of narcotics turn to barbiturates or alcohol when they cannot get enough narcotics to support their habit. Abusers of stimulants and hallucinogens sometimes take barbiturates to help calm drug-related anxiety.

Regularly using more barbiturates than a doctor prescribes can lead to psychological and then physical dependence. Physical dependence on "down" is just as severe as heroin dependence, and withdrawal is even more physically dangerous. Barbiturate withdrawal requires medical supervision.

Methaqualone is a sedative that is also referred to as quaaludes, ludes, sopors. Methaqualone can be used as a party drug with many people taking it to help them feel freer and not as

49

uptight. This causes another problem—as a party drug, it can be combined thoughtlessly with alcohol. The two interact to create a multiplied effect.

Tranquilizers are sedatives used to quiet or calm a patient's emotions without changing his or her ability to think clearly or stay alert. They do not have as strong a sedative effect as barbiturates, but they reduce anxiety.

There are two basic types of tranquilizers—major and minor. Contrary to what their names might imply, those which produce the "best" feelings are the minor tranquilizers. Minor tranquilizers are used to treat the symptoms of disorders such as nervousness or anxiety. Major tranquilizers are used to treat more severe mental disorders, such as manic depression or psychotic disorders. As a rule, major tranquilizers do not provide the feelings of emotional relaxation that the minor tranquilizers do. Almost all minor tranquilizers have the capacity to be abused, some more so than others. Tranquilizers which are abused include Ativan, Azene, Diazepam, Librium, and Valium.

Over the past 20 years, minor tranquilizers have been prescribed freely by doctors to help patients handle nervous feelings. However, it has been learned that these are not drugs to be taken lightly and their medical use has become more careful. Overdoses can happen—a result of taking too many tranquilizers at one time. It is possible to develop both a physical and psychological dependence on them.

One of the most deadly combinations of psychoactive drugs is the mixture of alcohol with any of the sedatives. Each potentiates the effects of the other. Sometimes the effects are stronger than the body can handle. The results of this mixture can slow down breathing so much that the brain becomes oxygen starved. Coma, permanent physical damage or death may result.

HALLUCINOGENS

To hallucinate means to have imaginary visions—to see, hear, taste or smell things that are not really there. The hallucinogens are drugs which can produce great changes in perception. Vivid changes in color and form occur. What any one person experiences when taking a hallucinogen is almost always different from what anyone else experiences taking the same drug at the same time. The effects of an hallucinogenic drug are strongly influenced by the thoughts, environment, and people who are with the user when the drug is taken.

Sometimes the user becomes disoriented, losing the sense of time, place, and identity. Sometimes the user has sensations of knowing and feeling what life is all about but is unable to express or remember clearly this supposed awareness. Emotions flood the user's mind and can be overpowering. For some, these experiences seem to be revealing or enlightening. But the altered perceptions can be confusing and frightening, and such experiences are referred to as "bad trips".

LSD is the most frequently used hallucinogen. Small amounts can produce dramatic changes in perception and emotion. While marijuana is measured in grams and most sedatives are measured in milligrams, LSD is measured in micrograms. LSD effects last for six to ten hours. Because of this length of time and the user's altered perception of time, the user can panic that the LSD effects will be permanent. Interestingly enough, antipsychotic drugs can be used to bring down a user who is having a "bad trip". In a small number of users, LSD has in fact triggered psychotic or schizophrenic breakdowns. More often, LSD users report flashbacks, i.e. spontaneously reexperiencing LSD effects to some degree.

Phencyclidine (PCP) is a drug used legally in veterinary medicine as an animal tranquilizer and general anesthetic. It is manufactured for illegal street use in both powder and tablet form. It can be swallowed or snorted, but it is usually sprinkled on either parsley or marijuana and smoked like a cigarette. Street names for PCP include Angel Dust, Hog, and Peace Pill.

PCP is a powerful and harmful drug, even in small amounts. Users report that it makes them feel distant and separate from their surroundings. Time seems to pass slowly; body movements slow down; muscle coordination becomes poor. The user may stagger as if drunk on alcohol. The sensations of touch and pain are dulled. Some users say they feel strong and powerful—like nothing can harm them—after taking PCP. This sometimes leads to serious accidents or acts of violence resulting in tragedy.

People who use PCP over and over again have trouble remembering things and may stutter when they talk. Many users of PCP have ended up under psychiatric care or institutionalized. These problems may last from six months to a year or longer after a person stops taking PCP.

NARCOTICS

Narcotics relieve pain anywhere in the body. Most of the narcotics are processed from the opium poppy. Synthetic narcotics have been developed in the laboratory in more recent years. Narcotics are valuable prescription drugs for the physician. Morphine is a painkiller. Codeine is used in cough medicines because it helps stop severe coughing. Paregoric (opium dissolved in alcohol) is used to stop diarrhea and teething pain.

One narcotic—heroin—is illegal even for doctors to prescribe or use. Heroin can be obtained on the street in the form of a white or brown powder that can be sniffed, injected, or swallowed. It is often mixed (cut) with other substances that look like it—starch, white or brown sugar, powdered milk, cocoa, quinine, or even strychnine (a poison). Users can rarely be sure of exactly what they are buying.

As useful as narcotics are in controlling pain, there are problems and dangers associated with their use. Users first become psychologically dependent on the feelings of pleasure that narcotics produce. After a relatively short period of use, the user will develop tolerance and will need more of the drug in order to get the same high. This can develop into physical dependence wherein withdrawal symptoms begin, if the user does not get the drug.

Depending on the extent of physical dependence, the symptoms can be minor or severe. The person shakes, sweats, and vomits. Eyes and nose run; muscles ache. Chills, abdominal pains, and diarrhea develop. The desire to avoid these uncomfortable withdrawal symptoms can become part of the reason for not "kicking the habit".

To prevent withdrawal, the heroin user must have a steady supply of the narcotic. Heroin addicts find that they must have two or more injections daily if they want to avoid withdrawal. As the dependency advances, the amount needed to produce euphoria continues to increase. This makes the size of the dose needed to produce the desired effect greater and greater. Heroin is illegal, so it is expensive. A dependent user needs at least $100 to $400 a day to maintain a habit. After some time, and without medical treatment, the addict begins to live only for the drug. He or she will do almost anything to get money for the habit.

There are other dangers for users. If the narcotic is taken in too large a dose, the user may die. The purity of heroin purchased on the street varies significantly. Five percent purity is common. However, a danger for the user is that he is never sure what the purity is. Unknown dose is the reason for deaths due to heroin overdose. Infections from using unsterilized equipment are common. Sharing needles is a primary means by which AIDS is spread. Babies born to mothers who are heroin addicts are born physically dependent on heroin and must be weaned slowly from the drug.

INHALANTS

Inhalants constitute a broad category of common substances that can be used as psychoactive drugs. Glues (especially airplane glue), spray paints, aerosols, paint thinners, and gasoline are common household products that have been used as inhalants. Other substances which have the potential for abuse are substitutes for cooking oil (PAM), correction fluid (white-out), lighter fluid, and charcoal starter. If the fumes of these products are sniffed or inhaled, they can produce a mind change similar to a mild hallucinogenic high. An inhalant high usually lasts for a much shorter amount of time—only about an hour.

Because inhalants are cheap and easy to come by, they tend to be abused by young people more than adults. Luckily, most young people who try an inhalant do not go on to use it regularly. Inhalants are often unpleasant to use and can be deadly.

A person who is sniffing an inhalant typically has trouble keeping his or her balance, has a glassy stare, and finds it hard to talk. The user feels drunk and dream-like. Good judgement becomes clouded. Occasionally a user breaths too deeply and inhales enough chemical fumes to pass out. If the user inhales a substance out of a plastic bag, there is danger of suffocation.

Even moderate use of inhalants over short periods of time can cause severe physical problems. Weight loss, liver and kidney damage, bone marrow changes, and even permanent brain damage have been found in users.

SUBSTANCES IN COMBINATION

All substances taken internally, whether swallowed, injected, or inhaled, combine and react with each other. The only safe rules to follow are those laid down by the individual's physician or pharmacist. One of the responsibilities of those who prescribe and dispense prescription drugs is to avoid combining drugs which have known toxic reactions. If the opportunity is present for adverse reaction caused by the combination of prescribed drugs of known doses, the opportunity for adverse reaction with the combination of illicit drugs or drugs taken without a physician's direction is multiplied.

Not only do all substances interact with each other (sometimes with moderate, sometimes with pronounced consequences) but also people vary in their responses to substances or the combination of them. This makes combining substances especially risky and hard to predict. A substance or combination of substances which one person may take with little apparent effect can be life threatening or fatal to others.

When combined, some substances have especially toxic effects. Alcohol is one substance which tends to pose a significantly increased danger when used in combination with other drugs, either licit or illicit. Alcohol and many other substances, particularly sedatives, potentiate each other. The cumulative effect of combining alcohol and other sedatives is not like that which would be expressed by a simple arithmetic progression, i.e. one drink plus one pill equals two doses. Instead the effect can become quite unpredictable, i.e. one drink plus one pill does not equal two, but equals some unknown, greater factor than what would normally be expected.

Another danger inherent in combining alcohol and other substances is the tendency for toxic build-up of those substances which are more difficult to eliminate. Some drugs stay in the system for long periods, making accurate estimates of the amount remaining in the system difficult or impossible.

The half life of valium, a common tranquilizer, is approximately 24 hours (one day). The half life of marijuana is three to four days. Half life means refers to the time it takes for one half of the chemical present at any one time to be eliminated from the system. If a person takes 40 milligrams of a drug with a half life of 24 hours, tomorrow he will have 20 milligrams still in his system. The next day 10 milligrams, and so on.

The half life of other substances of abuse is: Heroin, 12 minutes; Cocaine, approximately 1 hour (from 45 minutes to 90 minutes); LSD, 1 hour and 45 minutes; Morphine, approximately 2 hours (from 1 1/4 hours to 3 1/2 hours); Amphetamines, approximately 1 day (from 10 to 34 hours); Methaqualone, approximately 1 day (from 10 to 43 hours).

The body cleans itself of substances in the order of their chemical complexity, with the simpler ones being eliminated first. Alcohol is a relatively simple solution and is oxidized by the liver ahead of the more complex substances. Thus, more complex substances tend to remain in the system longer when combined with alcohol.

There is no known "safe" high. For each, there is a physiological and psychological price which must be paid. Sometimes the price is immediate, as was the case for Len Bias, the promising young basketball star who died of a drug overdose the first time he experimented with cocaine. Sometimes the cost is more difficult to determine, as is the case for those who reach less than their full potential because of substance abuse. The younger an individual is when they begin substance use, the more profound the long term effects tend to be.

Growing up physically, mentally, and emotionally is seldom easy. When someone chooses to add the complications of mind altering chemicals to the process of growing up, it typically becomes more difficult. There is also the chance that the damage done by substance use may be irreversible, such as a serious or tragic automobile accident. We cannot retrieve that which we have squandered. We cannot return to "go" and start over. Each person pays some price for substance use.

COMMON LICIT AND ILLICIT DRUGS, THEIR EFFECTS ALONE AND IN COMBINATION WITH ALCOHOL

DRUG	SOLO EFFECT	EFFECT WITH ALCOHOL
Antihistamines (cold remedies,cough medicine, allergy preparations, hay fever medications and decongestants)	Drowsiness	Effects sharply increase.
Aspirin and other Non-Narcotic Analgesics	Drowsiness	Increased chance of stomach bleeding. Existing ulcers get much worse.
Pain Relievers	Drowsiness or even greater sedation.	Possible death from respiratory arrest.
Tranquilizers	Cloud judgement, slow reflexes, hamper eye-hand coordination, slow brain activity.	Effects of tranquilizers intensified, and can reult in coma or death.
Stimulants (from caffeine to cocaine)	After the initial alertness come nervousness, dizziness, loss of concentration and visual problems.	Alertness leads to false sense of security and does not restore the loss of coordination caused by alcohol.
Marijuana	Interferes with coordination, false sense of control, double vision, reduced night vision, reduced tracking ability.	More hazardous than either alone.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

AIDS is a relatively new disease that was not diagnosed in the United States until the early 1980's. Since that time, more than 55,000 cases have been reported to the National Center for Disease Control. Nearly half of those diagnosed have died thus far. AIDS is a frightening disease because it is typically fatal. Let's review basic facts about AIDS.

AIDS stands for Acquired Immunodeficiency Syndrome. It is a disease caused by Human Immuno Deficiency Virus (HIV). It gradually destroys the body's ability to fight off illness and can damage the brain. AIDS itself does not kill. But it allows other illnesses (such as pneumonia or cancer) to develop and eventually kill the person.

There are three recognized stages in the progression of those who develop AIDS.

Stage I: HIV Positive. These people have been infected with the virus but show no symptoms or apparent illness. However, blood tests can detect the presence of antibodies to the virus. These individuals generally are not aware of the infection but can spread the virus to others.

State 2: AIDS-Related Complex (ARC). Symptoms have begun to develop. These symptoms can include loss of appetite, weight loss, fever, tiredness, diarrhea, skin rashes, and swollen lymph nodes.

Stage 3: AIDS. The immune system has been weakened and other infections invade the body. Pneumonia and skin cancer are two of the more common and serious illnesses. Damage to the nervous system and brain may occur in the form of memory loss, loss of coordination, and partial paralysis.

Not everyone who tests positive (Stage 1) has automatically progressed to ARC (Stage 2) and then to full blown AIDS (Stage3). Because AIDS has been diagnosed only in recent years, long-term studies have not been done. The long-term picture is complicated by the fact that the virus can have an incubation period of up to five to ten years before symptoms appear. At this time, it is thought that two-thirds of those who test positive will progress to Stage 2 (ARC) or Stage 3 (AIDS) within five years.

Myths about AIDS have arisen out of fear and ignorance. Such myths are not harmless; they are dangerous because they spread misinformation. Behavior change based on accurate information is the only method now available to reduce the spread of AIDS. Most myths center around how AIDS is spread. Let's examine these myths and get the facts straight.

Myth: The whole issue of AIDS is a mystery, with little factual information available.

The truth is that over 500 research articles are published each month on the subject of AIDS. A good deal is known about the disease. Virtually all questions about AIDS have been answered except how to cure it or how to make a vaccine to prevent AIDS.

Myth: AIDS is a disease of male homosexuals only.

Most AIDS victims in the United States are male homosexuals. Homosexuals comprise nearly three-fourths of the AIDS cases. However, in the future it is expected that male homosexuals will make up a smaller and smaller portion of the AIDS cases. IV drug use is the second leading cause of AIDS, accounting for nearly one-fifth of the cases. Homosexual behavior and IV drug use account for over 90% of the known cases of AIDS. Sex between a male and a female can transmit AIDS, when one of the partners is infected or a carrier. In Africa, heterosexual transmission is the leading cause of HIV infection. AIDS is a disease which can infect male or female, homosexuals or heterosexuals.

Myth: You can get AIDS from touching or from other casual contact.

Not so. AIDS is not transmitted by casual contact. There are no known cases where AIDS has been transmitted just from living with or being around an infected person.

Myth: AIDS can be transmitted by saliva, tears, or urine.

To date, no case of infection by saliva, tears, or urine has been reported. However, insignificant amounts of the AIDS virus can be found in these body fluids. Far greater concentrations are found in blood and semen, the only two body fluids known to have transmitted the disease.

Myth: AIDS can be contracted by using the same door knobs, towels, telephones, toilet seat, money, machinery or bar soap.

AIDS cannot be transmitted by inanimate objects. The AIDS virus does not survive outside the body.

Myth: A blood donor can acquire AIDS.

Absolutely false. Fresh, sterile instruments are used for each blood donation. However, receipients of blood transfusions have acquired AIDS in the past. Now an AIDS screening test is given to all potential blood donors to help ensure that contaminated blood is not donated for use by another person.

Myth: AIDS can be transmitted in the workplace or at school.

AIDS is spread only by sexual contact or exchange of blood with an infected person. There is a miniscule risk of infection for healthcare workers who are careless or do not take basic safety precautions. Nine healthcare workers have become infected after they accidently stuck themselves with AIDS contaminated needles or were splashed on open cuts or sores with AIDS tainted blood.

Myth: Children risk AIDS infection by attending school with an AIDS victim.

This has not happened, even with the occasional fighting, biting and scratching that occurs between children. AIDS is only transmitted by sexual contact or by exchange of blood.

Myth: Mosquitoes spread AIDS.

AIDS is not transmitted by mosquito bites. If it were, vast numbers of children would be infected.

Myth: It is possible to reduce the risk of AIDS by the use of special soaps, disinfectants, or sprays.

AIDS is not spread on environmental surfaces. Those products are useless gimmicks. In fact, skin is an excellent barrier to the AIDS virus unless it is broken.

Myth: Men cannot acquire the AIDS virus from intercourse with an infected female.

Heterosexual contact is one method to transmit the AIDS virus. However, the likelihood of transmission is not as great compared to homosexual contact, IV drug use, or other exchange of blood. It is far easier for a woman to become infected during intercourse with an infected male, rather than vice versa. This is because semen has a greater concentration of the AIDS virus than do vaginal secretions. It is nonetheless possible for the male to become infected, especially if his genetalia has scratches or abrasions.

At present, the number of teenagers with AIDS is relatively low. Two percent of the AIDS cases in Missouri are between the ages of 15 and 19. However, once AIDS enters a particular population it spreads unless high risk behaviors are avoided. Because adolescence is often a period of experimentation and risk taking, some experts are concerned about the future rates of AIDS among adolescents.

You can avoid exposure to AIDS by avoiding high risk behaviors. High risk behaviors include homosexual activity and IV drug use. Heterosexual activity with multiple partners also increases your risk of exposure. Condoms or rubbers can reduce the risk of AIDS being transmitted through sexual activity.

Free AIDS testing and counseling is available at fourteen sites in Missouri. (See page III-14 in Appendix III.)

HIGH RISK SUBSTANCE USE

Substance use is not healthy for the mind or body and there is no such thing as a completely safe "high". However, some forms of substance use are even more dangerous than others. Let's brainstorm about the more high risk forms of substance use.

Instructor Note: Ask the class to brainstorm and identify high risk forms of substance use. Be sure that the class discussion includes: (1) using and driving or operating machinery; (2) mixing or combining substances; (3) taking street drugs where the substance, purity, and dose are not known; (4) shooting or using drugs intravenously; (5) being pressured by friends or acquaintances to use more than you really want to or than you decided to use at the outset; (6) drinking "drink for drink" with a more experienced drinker or someone who is much larger or more muscular than you; and (7) consuming large amounts of alcohol in a brief time. Games or contests like "Chug-a-lug," "shot gunning," "doing shots," "Cardinal Puff," "quarters", or "caps" which induce the participants to drink large amounts of alcohol in a short time are all dangerous and should be avoided. Emphasize that all of the behaviors listed increase the likelihood of harm to oneself or others.

EFFECTS OF SUBSTANCE USE ON DRIVING SKILLS

MAGNITUDE OF THE DRINKING AND DRIVING PROBLEM

- Approximately 43,000 people were killed in traffic accidents in the United States last year.

- Approximately one half of those deaths were alcohol-related.

- Ten years of war in Vietnam caused 46,000 United States battle deaths, but only two years of alcohol related traffic accidents produce the same number of deaths. Over 500 of these deaths happen in Missouri.

- Every 19 minutes an alcohol-related automobile death happens in the United States.

- Automobile accidents are the third greatest killer of Americans, right behind heart disease and cancer.

- Automobiles are the number one killer of people under 25 years of age. 40% of all teenage deaths result from automobile crashes.

- 8,000 high school students are killed each year in accidents involving alcohol.

- 85,000 teenagers were injured in alcohol-related accidents in 1986.

- Accidents caused by intoxicated drivers tend to be more severe than accidents caused by sober drivers. Alcohol-related accidents are twice as likely to result in injury as are accidents in which alcohol is not involved. Alcohol related accidents are ten times more likely to result in death than non-alcohol crashes.

- The drunkest 7% of drivers account for 33% of all traffic fatalities.

- In single-vehicle accidents in which the involved driver is almost certainly at fault for the accident, the percentage of dead drivers who are intoxicated is much higher than 50%.

- Besides killing themselves, drinking drivers are responsible for the deaths of many innocent people. Out of every 1,000 deaths caused by drinking drivers, 411 are sober drivers, sober passengers, and sober pedestrians.

- Drunk driving injures 650,000 people per year in the United States.

- Drunk driving also causes billions of dollars per year in economic losses. Missouri's annual share of that loss is conservatively estimated to be at least $250 million.

- Drinking drivers kill and injure more people in Missouri than does any other single group.
- In 1987, 259 Missourians died in automobile accidents caused by drinking drivers.
- In 1987 another 8,697 people in Missouri were injured in accidents caused by drinking drivers.
- Nearly 50% of the people injured and killed in Missouri automobile accidents are under age 25.

As a result of these tragic statistics, 49 of the 50 states now have a minimum drinking age of 21. Although this does not absolutely prevent drinking or drinking and driving by those under age 21, it has saved approximately 1,000 lives per year.

The laws in Missouri regarding drinking and driving have become more strict in recent years in growing recognition of the danger of drinking and driving. "Abuse and Lose" is the latest and most stringent of the laws. Missouri is one of a handful of states that have established license revocation for those under age 21 who drink and drive or who drive and have alcohol or drugs in their possession.

(Optional) Utilize a guest speaker whose personal experience highlights and makes real the tragedy and suffering caused by drinking and driving. A representative from Mother's Against Drunk Driving or a victim of drunk driving might be appropriate. An offender whose drinking and driving behavior caused serious injury or death might also be suitable.

EFFECTS OF ALCOHOL ON DRIVING SKILLS

Alcohol, even in small amounts, impairs a driver's ability to correctly sense, decide, and act.

Vision is the primary method to receive information with ninety percent of driving information coming from vision. Alcohol reduces your ability to see. It reduces visual accuracy, makes it hard to focus, and causes blurring and even double vision. Alcohol reduces your ability to see at night. It reduces your field of vision or peripheral vision. Alcohol slows your eye's ability to recover from the glare of headlights by up to seven seconds.

In addition to your ability to get accurate visual information, alcohol impairs your judgement. Even at low doses, alcohol affects your judgement, thinking, and inhibitions. When driving, you must make the right decision and make it quickly.

Alcohol impairs reaction time:

-- BAC .05% - reaction time is impaired 20%

-- BAC .10% - reaction time is impaired 33%

-- BAC .12% - reaction time is impaired 70%

Drinking drivers drive too slow or too fast; they make wide turns; they do not drive within their lane; they may disregard traffic signals.

Studies have determined the extent to which BAC levels increase the probability of having an accident:

-- BAC .05% - probability of an accident doubles

-- BAC .10% - probability of an accident is six times greater

-- BAC .15% - probability of an accident is 25 times greater.

(See page III-1 in Appendix III for a graph.)

These are averages for all drivers and are underestimates for adolescents who are beginners at both drinking and driving. Their experience in each area is limited. Thus their drinking and driving behavior is even more unpredictable and dangerous.

EFFECTS OF MARIJUANA ON DRIVING SKILLS

Marijuana impairs driving skills. This conclusion comes from studies using test course performance, driving simulators, and actual street driver performance. These studies consistently show that stoned drivers react slower and make more accident-causing mistakes. Studies from Massachusetts and California indicate that the driver in approximately 15% of fatal accidents was stoned. Tests with experienced pilots who received less than one joint demonstrated that on a flying simulator they made six times as many minor mistakes and seven times as many major ones, compared to when they took the test straight.

How does marijuana cause such impairment? By impairing thinking, judgement, reaction time, and psychomotor coordination. Thinking and reflexes are slowed, making it hard for drivers to respond to sudden, unexpected events. Judgement is affected. Drivers using marijuana having trouble maintaining a constant speed and keeping the proper distance between cars. They have trouble making accurate estimates of the time it takes to pass. Reaction time is impaired with it taking longer to brake and bring the car to a stop. Part of the slower reaction time may be related to the fact that marijuana distorts one's sense of time. After using marijuana, people experience time as moving slower. Perhaps that is why some stoned drivers think that they drive better: things seem to move slower, so the driver falsely believes that he has more time to react. The truth is that marijuana slows down reaction and the driver is, in reality, less in control of the driving situation. Thus marijuana can impair not only the ability to drive, but it can give the false belief of being capable or in control.

Marijuana impairs perception and psychomotor coordination essential for safe driving. For example, a driver using marijuana has difficulty staying in the proper lane on a curve. We previously established that 90 percent of the information necessary for driving comes from our sense of sight. Marijuana impairs vision. It takes the eyes longer to recover from headlights or other glare. Marijuana can cause double vision. However, the visual ability most severely affected is visual tracking, i.e. the ability to accurately follow the path of an object.

While a marijuana high lasts two to three hours, marijuana impairs driving skills for approximately six hours. Therefore, someone can feel straight but actually have their driving skills impaired. Poor concentration and delayed reaction time are the two skills that are most affected during this lag time.

We have all heard the adage—"If you drink, don't drive." We should add another safety tip—"If you smoke pot, drive not."

When alcohol is combined with marijuana, the risk of an accident greatly increases, and driving skills are much worse. The combination may be tempting, especially because smoking irritates the mouth and throat and drinking may seem to relieve the discomfort. Both alcohol and marijuana have sedative qualities and disrupt many mental functions. When combined, they cause "double trouble," particularly in concentration, reaction time, visual tracking, and psychomotor skills.

Not only is the degree of impairment worse from combining these two substances, but also the impairment lasts longer than taking just one of the substances. Remember that alcohol is a relatively simple chemical compound which the body eliminates first; then the body begins to work on the more complex chemical, in this case marijuana. The time to eliminate all the chemicals and their effects is extended.

Using substances and driving is especially hazardous for the adolescent who is relatively inexperienced in driving. Adolescents may also be more tempted to drive impaired because they tend to use the automobile as a "portable living room".

One of the most dangerous aspects of driving under the influence of alcohol and/or marijuana is that the user does not realize his degree of impairment. Both substances give the subjective sense of feeling better and more competent. The user feels he is operating at a higher level of ability and confidence. He may thus take chances or run risks that are counter to his normal good judgement.

SUBSTANCE ABUSE AND DEPENDENCY

DISEASE CONCEPT

Alcohol dependency is a problem which has plagued man since he first learned to make alcohol. References to alcohol and drunken behavior abound in our literary, historical and religious writings. Most efforts to deal with alcoholism in the past have been based on the premise that it was a sign of immorality or weakness.

The first real breakthrough for another view of alcoholism came in 1935 when Alcoholics Anonymous (A.A.) was founded. The following view is expressed in A.A. literature: "Most of us agree that, for us, alcoholism could be described as a physical compulsion, coupled with a mental obsession. We mean that we had a distinct physical desire to consume alcohol beyond our capacity to control it, and in defiance of all rules of common sense. We not only had an abnormal craving for alcohol, but we frequently yielded to it at the worst possible times." Although this passage does not specifically use the terms psychological dependence or physical dependence, it does describe them.

- In 1951 the World Health Organization identified alcoholism as a disease.
- In 1953 the American Psychiatric Association classified alcoholism as a disease.
- In 1956, the American Medical Association defined alcoholism as a disease in the following terms:

  "Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments as a direct consequence of persistent and excessive use of alcohol."

  (See pages III-20 through III-25 in Appendix III for the DSM III - Revised description of Substance Dependence and Abuse.)

Chemical dependency, like alcoholism, has come to be viewed as a disease. The dynamics are quite similar. There can be two different components of alcoholism and some chemical dependency—psychological dependency and physical dependency. The psychological part corresponds to the compulsive behavior pattern. Those who drink or engage in any destructive, unhealthy activity against their better judgement or against the law, are quite likely engaged in compulsive use or showing psychological dependency.

The body's reaction to an addictive substance is characterized by tolerance and sometimes by physical dependency with accompanying withdrawal symptoms. The physical dependency occurs after frequent and extensive use. Tolerance refers to the body's need for increasing doses to achieve the desired level of intoxication. Substances vary in the level of tolerance or addiction they create. Initially the body tends to be very susceptible to the effects of alcohol or drugs, but as the individual experiences more of the substance he tends to develop a "tolerance" for it. After a period, more of the same substance is required to achieve the same level of feeling. If, for example, a beginning drinker can "feel" one or two drinks, then in all probability after a period (months or years) of drinking, he will become tolerant to the effects of alcohol and will need more to achieve the same feeling. In many cases, what is referred to as the ability to "hold one's liquor" may actually be tolerance. Because of tolerance, alcoholics often have high BACs when picked up for a drinking and driving offense.

Withdrawal symptoms occur when the use of an addictive substance is stopped after extensive use. The body has become accustomed to the presence of the substance and has a withdrawal reaction. The severity of withdrawal symptoms varies from substance to substance and from individual to individual.

A modern view of alcohol and drug dependency sees it as being primary, i.e., it is not caused by something else. It was once thought of as secondary to some other mental or psychological disorder. It was thought that once the underlying problem was diagnosed and cured, the alcohol or drug dependency would go away. Most authorities now reject that thinking. Chemical dependency may be prompted and promoted by many different reasons. However, to have any success at all in overcoming chemical dependency, it is first necessary to treat the dependency itself. As a disease, chemical dependency is:

1. **Identifiable.** The symptoms can be described. Chief among them is the compulsion to use, even though the use is inappropriate, unpredictable, excessive and/or constant.

2. **Primary.** It is not the direct result of some underlying condition. However, it can cause or aggravate other conditions.

3. **Progressive.** There is often a predictable course. Left untreated, chemical dependency often gets worse.

4. **Chronic.** Once someone becomes dependent, they are subject to relapses.

5. **Fatal.** Continued use often is fatal because of damage to the body or increased risk of dangerous accidents. Approximately half of traffic deaths are due to an impaired driver. Eighty percent of deaths by fire are alcohol or drug related. Seventy percent of drownings involve substances. Seventy percent of fatal falls are alcohol or drug related. Twenty-five percent of all alcoholics die before the age of 50.

GENETIC FACTORS

There is strong evidence that certain individuals have a genetic predisposition to alcoholism. There is a tendency for alcoholism to "run" in families. If a parent is alcoholic, the likelihood of the children developing alcoholism dramatically increases. The question then arises - Is the fact that alcoholism tends to run in families due to socialization and learning or is it due to a genetic predispostion? Studies tend to indicate that genetic predisposition is the more powerful reason.

The Scandinavian Adoption Studies followed identical twins who were adopted at birth. Those children who were born of an alcoholic parent had a higher incidence of alcoholism themselves than did children whose parents were not alcoholic. A 1983 study documented a rate of alcoholism among sons of alcoholics adopted at an early age that was four times as great as that of a control group of adoptees. Further, this greater rate among sons of alcoholics did not differ significantly whether they were raised by alcoholic or non-alcoholic adoptive parents. Another study cites an alcoholism rate of four times the control group of adopted away daughters of alcoholic mothers.

The Scandanavian Adoption studies identified two types of alcoholism which seem to be genetically transmitted: (1) milieu- (environmental) limited and (2) male-limited. The milieu-limited type occurs more frequently, includes both sexes, requires environmental provocation and generally is less severe than is the other type. The male-limited type occurs when the biological father is alcoholic and tends to transmit alcoholism only to male offspring. This type tends to be more severe, has an earlier onset, is characterized by fairly serious legal difficulties, and often requires extensive or repeated treatment.

Research has also documented that the ethanol reactions of sons of alcoholics differ from normal or social drinkers. When given low to moderate doses of alcohol, the sons of alcoholics rate themselves significantly less intoxicated than do the control group. This could

75

mean that the sons of alcoholics have an impaired ability to fully experience the effects of moderate doses of alcohol. It is more difficult for them to know when they are becoming intoxicated. This apparent biological tolerance to alcohol could possibly prompt the sons of alcoholics to drink more to attain the same effects others feel at lower BAC's. This then could be a factor in the early heavy drinking of many alcoholics.

Other data which supports the genetic predisposition toward alcoholism comes from animal breeding experiments and studies with humans which identify brain wave differences and biochemical markers associated with alcoholism. Breeding experiments with animals provide evidence that genetic factors influence alcoholism. Animal lines have been bred that differ in their response to alcohol, their oxidation or breakdown of alcohol, the rate at which tolerance develops, and the severity of withdrawal symptoms.

The brainwave and biochemical studies have identified specific markers which support the premise that alcoholism can be transmitted genetically. Researchers have been able to identify brainwave differences in both alcoholics and their offspring. Notable among these differences is the P_3 wave, which is markedly reduced in male alcoholics and many of their young sons.

Much progress is being made in the identification of chemical markers related to genetic transmission of alcoholism. Interest is being focused on the enzymes which breakdown or oxidize alcohol. The reaction that many Orientals have to alcohol (a flushing of the skin and nauseau) has been related to the absence of a form of the ALDH (aldehyde dehydrogenase) enzyme. It is believed that the absence of this enzyme may account for the low rate of alcoholism among Orientals. Another potential biochemical marker of inherited susceptibility to alcoholism is a low level of MAO (Monoamine Oxidase) in blood platelets. The level of MAO is basically genetically determined. Alcoholics and their children have lower levels of MAO. A relationship has been established between the male-limited type of alcoholism and low levels of MAO. In the future, there may be a blood test which can identify those at increased risk of alcoholism.

PROGRESSION OF DEPENDENCY

No one starts out planning or intending to become chemically dependent. Dependency is a state arrived at, after a period of increasing use accompanied by increasing problems. No one becomes chemically dependent at first use. Everyone starts at the same point of initial non-problematic use. For some, this use progresses to regular use, then abuse, and finally dependency.

The beginning experimental phase can end with the user deciding to discontinue. The chemical use can be so enjoyable or compelling that the user graduates from experimental, to occasional, to regular use where he integrates chemical use as part of his life. For some, this is as far as the progression goes; others continue on to substance abuse and dependency. Not every one who experiments with chemicals will progress to the later stages, but those who do must progress through the stages just described. The healthiest and safest rule to follow is to not begin substance use at all.

We begin chemical use not so that we can become dependent but instead for social reasons or the good feelings or desired effects of the substances. Those of us who do become chemically dependent do not plan or intend to do so. It is not possible at this time to accurately predict who will and who will not move from initial to regular use to substance abuse and dependency.

Most people start using to obtain social acceptance or to deal with pressure from friends to use. Sometimes there is a person we admire who uses and we use to be around that person or to be like that person. We can enjoy their company and learn from them, while using.

Soon we begin to drink or use other drugs in excess. We are moving from using for acceptance to using for the mood and mind-altering effects. Friends and peers often reward us or give us strokes for becoming intoxicated or high.

77

Most people start using in their teenage years. It is a time in our lives when we are unsure of ourselves. We are dealing with puberty and our sexual roles. We are emotionally moving away from our families and trying to find our place in the bigger society. We have a lot of challenges, confusions, and discomfort.

And substance use can ease the tension or discomfort for the moment. It can ease our awkwardness and anxiety in social situations. It can seem to make it easier to talk to others, especially those of the opposite sex. So we have come to a point where we drink or use for comfort. We do it to relax and to forget troubles.

We may come to a point where we psychologically rely on the substance to make us feel better or act differently. We may mistakenly think that our boldness and confidence comes only with the substance. We drink a little faster or use more of the drug. We use more and more frequently. We are crossing the line into problem use. And there is an emotional price that gets more and more "expensive". We are robbing ourselves of opportunities to learn how to cope, how to relax, how to be assertive, how to handle problems. We have come to a point where we have brought substance use into more and more parts of our lives. And although we will be the last to admit it, we may reach a point where substances affect or control much of our lives.

(For further information, see page III-19 in Appendix III.)

RECOGNITION OF SUBSTANCE ABUSE AND DEPENDENCY

Substance abuse does not exist in a vacuum. The user must have encouragement and help to start and continue a pattern of use. Obvious sources of help are the suppliers of alcohol and drugs and the peers who encourage substance use and build much of their social life around obtaining and using substances. However, family and others can unintentionally contribute to the problem. This can take the form of family members, friends, or school officials refusing to recognize the problem for what it is and "helping" the individual by allowing them to make-up work, paying fines for them, making up excuses or believing alibis. Such helping, even if well-intentioned, can actually enable the user to continue using. It can enable the user to avoid the consequences of his or her use.

The number one symptom of all substance abuse is denial. The abuser denies his problem. But family may also deny the problem because no one wants substance abuse to be a part of their home. Consequently, the symptoms and signs of substance abuse are often seen but not recognized. It is easier to ignore them or hope they will go away. The signs may be minimized so that the problem must become severe before family members, employers, school officials, or friends are willing to see the problem for what it is. They can minimize by thinking, "It's just a stage" or "He's been under a lot of pressure" or "It's better to be coming home drunk than to be using drugs".

Warning signs of substance abuse or dependency include any dramatic or marked change in:

1. Friends
2. Behavior
3. Grades - Loss of interest in grades or school may be shown. Grades begin to drop. May skip class or school.
4. Interests - Former interests or activities may be discarded
5. Attention to physical appearance - May change dress style or begin to neglect hygiene.

6. Language (choice of words, subjects)

7. Attitude toward family members, school officials, other authority figures - May begin to use home like a "motel", i.e. a place to eat and sleep.

8. Secretiveness - May lock rooms, drawers, cars, etc.

9. Resentfulness at intrusion into their "space" - May seem to withdraw from the family.

10. Lack of predictability or accountability (time and/or money) - May not be as dependable and responsible as previously. May not follow curfew hours. May sneak money or liquor out of the house.

11. Disturbed eating pattern (ice cream, sweets, "munchies", lack of appetite, gorging, fasting, extreme thirst)

12. Physical signs such as: aroma of alcohol or burned weeds;bloodshot eyes; dilated or constricted pupils; slurred speech; lack of balance; rapid eye, hand or body movement; nose bleeds; tears or burns in clothes.

13. Mood swings and personality changes - Moods may become more pronounced and extreme. Many mind altering drugs can cause the user to be relaxed or euphoric during use. But with almost all drug action, there is an equal and opposite reaction. The user may experience a later period of tenseness, especially if they are becoming psychologically or physically dependent. Some people will demonstrate marked mood or personality changes and will be alternately pleasant and friendly and then grouchy or hostile.

An adolescent with a substance problem may not demonstrate all of these symptoms. However, most with a developing substance abuse problem will demonstrate several of them. As their dependence on alcohol or drugs grows, the more pronounced will be the symptoms. Some adolescents may show one or more warning signs due to situational problems and setbacks, that is, normal growing pains. However, in these circumstances, the warning signs are usually few in number and passing in duration.

Professionals look for the following symptoms or behaviors in assessing substance use:

-- substance often taken in larger amounts over a longer period than the person intended.

-- persistent desire or one or more unsuccessful efforts to cut down or control substance use.

-- a great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects.

-- frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated).

-- important social, occupational, or recreational activities given up or reduced because of substance use.

-- continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking).

-- marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

Note: The following items may not apply to cannabis, hallucinogens, or phencyclidine:

-- characteristic withdrawal symptoms.

-- substance often taken to relieve or avoid withdrawal symptoms.

If one or more of the above symptoms is present, then substance use has become abuse. If three or more of the symptoms are present, then substance use has become dependency. (See pages III-20 through III-25 in Appendix III for further information about the classification of substance abuse and dependency in DSM III-R.)

It is difficult for the user with the growing problem to see what is happening to him. The individual's own natural psychological defenses of denial, repression and projection make accurate interpretation of events nearly impossible. It is therefore essential that family members, friends, and other significant people in the substance abuser's life help them recognize the problem. Remember that the initial tendency of a family member or friend will be to minimize or deny the problem. It is important for the family and friends to realize what is happening. The next step is for them to clearly state the problem to the abuser, to not accept excuses and alibis and easy promises, to express concern and care, and to insist on change.

Almost without exception, attempts which are characterized by anger, yelling, lecturing, or accusing will have a negative effect. They will not help and they likely will make conditions worse. Very often the proper tone and approach can be best achieved by talking and planning with a professional who is trained in the area of alcohol/substance abuse and is knowledgeable about the most effective way to make an intervention.

EFFECTS ON THE FAMILY

The effect that substance abuse by any family member has on the others in the family is direct and profound. The question is not so much, "Is the family affected by substance abuse?", but rather, "In what ways and how much is it affected?"

The family can be pictured as a mobile in perfect balance with all members having a certain weight, position, or role. If any one family member alters his or her position, that altered position has an affect on all other family members. Very often the initial shift in position is so slight that it is almost imperceptible, but if allowed to continue, family positions and roles will significantly change. Usually family members of a substance abuser will try to restore the past balance to their family. However, these attempts are seldom successful.

Attempts at restoring balance to the family may include taking on additional responsibilities so that the substance abuser will not be so pressed. Such steps will only enable continued use, increase guilt or resentment in the user, and thus compound the problem.

The main concern of the individual using becomes the substance and ready access to it. They, of course, will deny that there is a problem. Or they may assert that if there is a problem, it is you, the teachers, the family, the police, the "clique" at school and so on.

In addition to the role of the user, there is the family role of "co-dependent". The co-dependent is one or both of the parents when the substance abuser is young. The co-dependents are the ones most responsible for tending to the needs of the substance abuser. As the problem progresses, so does the co-dependents' need to take care of or protect the substance abuser. The abuser's behaviors of omission and commission tend to become the co-dependent's responsibility and problem.

The effect of substance abuse on the family is remarkably similar from family to family. In a family distressed by substance abuse, warmth and mutual support among members evaporate and are replaced by other less healthy characteristics. The family members typically come to adopt a new set of rules to emotionally deal with the situation. These rules can be summarized as: "Don't talk; don't trust; and don't feel". Emotional sharing and closeness become nearly impossible with these rules. If the family structure is dysfunctional due to substance abuse, all family members recognize that intuitively and will not rely on the family. They will tend to go their own way. Important family ingredients are lost, such as dependability, predictability, and structure.

One of the common symptoms associated with dysfunctional families is losing touch with their real feelings and coming to have "frozen" feelings. Feelings can be masked through substance use, especially feelings that are painful and difficult to handle. Family members can deny their feelings through an "I don't care" thinking. Or they can lose touch with their real feelings through being overwhelmed by anger or frustration. Because family members have lost the normal supportive structure of the family and can no longer share genuine feelings, they tend to deny their feelings, lose touch with their feelings, or medicate them with alcohol or drugs. These coping methods may offer temporary relief from the discomfort, but ultimately fail.

In a family marked by substance abuse, there is little or no sharing of feelings. The members come to assume the worst about one another's intentions and behavior. The recognition of emotions may be ridiculed so that members become increasingly reluctant to expose any part of their feelings. The emotional dynamics of the family may compound the initial problem of substance abuse.

Emotional withdrawal from each other also causes the family members to increasingly misunderstand one another. Family members become judgemental and accusatory. They blame the family's problems on each other, but seldom seek to work together toward solving the family's problems and distress.

The family, both as individuals and as a unit, becomes increasingly dysfunctional along with the substance abuser. Consequently, once a family has become trapped in a dysfunctional pattern, often the only way to overcome the problem is with outside help, either professional family counseling or participation in a self-help family recovery group such as Al-Anon, Naranon, or Families Anonymous.

It has been estimated that there are nearly 10 million children under the age of 18 living with an alcoholic parent. Roles of children raised in a family where a parent experiences substance abuse or dependency have been described and better understood in recent years. Sharon Weigscheider-Cruse identifies the common roles of children as hero, scapegoat, lost child, and mascot. (See page III-18 in Appendix III for further information.)

The "Hero" usually is the first born and as a rule is looked upon as the "golden" child. Most often heroes attract positive attention through their socially desirable behaviors. They often excel in academics, sports, or social organizations and bring favorable recognition to themselves and their family. They appear quite mature, responsible, and healthy. However, they frequently have emotional problems later in life. They may feel driven to succeed or to be perfect. They focus on accomplishment rather than feeling.

The "Scapegoat", usually the second child, is quite often deprived of the positive attention which is given to the hero and deprived of the immense attention which the parent with substance abuse or dependency may receive. The scapegoat gets attention in negative ways through disruptive and acting out behavior. The scapegoat often is blamed for many family problems which are not really his fault. The scapegoat comes to act in a manner which will justify the accusations. The scapegoat often develops alcohol or drug problems.

The "Lost Child" tends to be withdrawn, a loner, whose most valuable contribution to the family is that he or she does not disrupt or demand attention. Because the family's attention is focused elsewhere, there is little attention available anyway. As the "lost child" gets older, he may struggle with loneliness, depression, and low self-esteem.

The "Mascot" usually is the family clown, the one who will do virtually anything to make the other family members feel better. The mascot takes on the job of relieving tension and lessening crisis. They are very sensitive to the moods and needs of others. When mascots reach adulthood, they have trouble recognizing and meeting their own needs and have trouble dealing with stress.

It is possible for the children to switch roles or for one person to assume more than one role at one time. If, for example, the hero moves away, the family may respond to this act by promoting another member to hero.

It is important to remember that these roles are uncomfortable and confusing to anyone in them. The symptoms of one family member, while different from those of others, are all symptoms of a dysfunctional family.

(Optional) The curriculum may include a guest or volunteer speaker, such as: (1) A parent who has participated in the recovery process with a child, describing how the substance use affected the family, how the problem was addressed and what the outcome has been; and (2) an Adult Child of Alcoholic parents discussing the effects of being raised in a dysfunctional home and the personal struggle to overcome childhood and family roles.

TREATMENT FOR ADOLESCENT SUBSTANCE ABUSERS

The three most common forms of recovery programs are Residential, Outpatient, and Self-Help Groups (most notably Alcoholics Anonymous and Narcotics Anonymous). Group medical insurance in Missouri is required to include coverage for treatment of alcoholism just like any other type of medical treatment. Group insurers are required to offer drug abuse coverage as an option. However, not everyone has "group" medical insurance. Those who do have medical insurance can also have what are called "self-insured" policies or "individual" policies. However, treatment is available even if one does not have group medical insurance. State funded programs charge on a sliding scale based upon family income and size. Often there is no charge or a minimal charge.

Residential

Treatment programs for adolescent substance abusers are generally longer in length than are programs for adults. Adolescent programs generally offer more physical activities and provide for continuing education.

Most residential programs for adults last approximately four weeks. However, residential programs for adolescents often last from six to eight weeks, with some programs lasting even longer. Residential treatment, as its name implies, provides a 24-hour a day alternative living environment. The client moves to the treatment facility and lives there during treatment. Some programs offer weekend or holiday leaves; others do not.

Treatment programs typically are based on the "whole person" philosophy where the clients are encouraged to restructure and rebuild their whole lives. Programs typically offer group and individual counseling sessions, substance abuse education, and family counseling. Some programs also offer counseling and education regarding use of leisure time, nutrition, spirituality, and dealing with stress. In addition to daytime activities, the clients may be expected to attend self-help meetings at night, either at the facility or meeting sites in the community.

Comprehensive programs will expect participation in the treatment process by as many family members as possible. Many programs believe that substance abuse by any family member effects the entire family and that recovery for any member involves the recovery of all.

Most residential programs will develop an Aftercare Plan with the client and/or family to be followed after discharge. The gains made through treatment in a controlled environment are new and tentative. Ongoing support and change are essential. Aftercare usually involves outpatient counseling, self-help groups or both.

Outpatient

Outpatient treatment programs typically have clients come to the facility in the afternoon or evening, making it possible for them to remain in school and live at home. Outpatient programs are obviously less structured than Residential ones. For some clients this is a disadvantage, and they cannot handle, in the initial stage of treatment and recovery, the reduced structure and relative freedom provided by an outpatient program. Other adolescent clients, especially those in the earlier stages of abuse and dependency, can handle the relative freedom of an outpatient program. Some outpatient programs try to provide more structure by having the client attend several sessions a week with each session lasting two or three hours. The frequency of sessions is then reduced as the client makes progress.

Another difference between residential and outpatient programs is the length of treatment. Residential programs for adolescents generally last one or two months with an Aftercare or continuing care plan then made with the client. Outpatient programs typically extend well beyond one or two months and try to provide both initial care and continuing care.

Outpatient programs generally rely on educational sessions and individual and group counseling. Family involvement is usually expected. Participation in self-help groups may also be expected. The combination of services that each person receives is a result of the individual's needs and the program's philosophy. For example, some programs rely on group education and counseling, while other programs may emphasize individual or family counseling.

Self-Help Groups

Self-help groups are based on the twelve steps to recovery first formulated by Alcoholics Anonymous (AA). AA has two different types of meetings: "open" and closed". Open meetings are, as the name implies, open to anyone with an interest in alcoholism. Closed meetings are for members only. AA's sole requirement for membership is not, as some believe, a confession of being alcoholic, but simply a desire to stop drinking. In many closed meetings, the members share their experiences, strength and hope with each other on a personal, informal basis with members talking or not, as they see fit. Open meetings are usually more structured with a speaker or speakers and with little or no time for discussion. In addition to the twelve steps, AA tends to rely heavily on the individual member's willingness to be available to their fellow alcoholics. This ability to rely on each other and help each other is one of the primary tenets of the program, and one which separates it from most forms of professional help. Each new member is encouraged to select an experienced member to be their sponsor. The sponsor is a person to turn to for guidance and support, particularly during times of crisis. The fellowship and mutual assistance of AA has helped it to grow and become widely available since its inception in 1935.

Three other types of self-help groups related to substance abuse are available in many areas. Alanon was established to provide support and meet the needs of spouses living with a substance abuser. Alateen later developed as a support group for adolescents. The most recent self-help group to be organized on a national basis is Adult Children of Alcoholics.

LIFE SKILLS

MOTIVATIONS

Chemically induced feelings of well being have been a part of man's history since the earliest of times. Man has known for a long time that it is possible to alter how he feels by the use of substances. Chief among these through history have been alcohol and marijuana.

People often drink alcohol or use some other substance in order to change how they feel. They do not necessarily need to feel bad to want to feel better. The desire to feel better or to feel different seems universal. How people achieve the feeling is sometimes different. Substance use is but one way.

Reasons given for substance use include: (1) be like others, to be part of a group; (2) reduce boredom or just to "find out" (curiosity); (3) reduce inhibitions and facilitate personal interaction (i.e., "party"); (4) increase self-confidence or courage; (5) rebel or defy authority; (6) take risks, "flirt" with danger, "showoff"; (7) relax physically; (8) change mood, relax emotionally, or reduce tension; (9) escape problems and feelings; (10) alter sensory perception—touch, taste, sight, hearing; and (11) meet a psychological and/or physical dependency that may have developed.

There may be other individual reasons or variations of these reasons. It is important to be able to look at oneself and to identify your individual reasons. You may have a number of reasons and they may change from one episode of use to another. However, to know yourself means to recognize your primary motivations.

Instructor Note: Have students complete the worksheet on the following page. In a small class that appears to be relatively open and involved, the worksheet may be replaced by class or group discussion.

MOTIVATIONS WORKSHEET

(Name) ______________________________ (Date) ______________________

This questionnaire is designed to help you (1) reconstruct the events and feelings surrounding your alcohol/drug offense, and (2) review your general feelings and motivations about using.

1. How would you describe the 12 hours preceeding your arrest?

   ___ A Usual Day
   ___ An Unusual Day

   If unusual, what was unusual? ________
   ____
   ____

2. What was your arrest/charge? ________
   ____

3. During what part of the day did you start using?

   ___ Morning (8:00 AM to Noon)
   ___ Afternoon (Noon to 4:00 PM)
   ___ Evening (4:00 PM to 8:00 PM)
   ___ Night (8:00 PM to Midnight)
   ___ Early Morn (Midnight to 8:00 AM)

4. What was the occasion for using?

   ___ Celebration/Party
   ___ After School/Work
   ___ Disappointment
   ___ No Special Occasion
   ___ Other (Specify) ______________
   ____

5. Did you have any of the following strong feelings when you started using?

   ___ Angry
   ___ Depressed
   ___ Lonely
   ___ Bored
   ___ Other (Specify) ______________
   ____

6. Where were you when you started using?

   ___ Home
   ___ School/Work
   ___ Friends Home
   ___ Car
   ___ Other (Specify) ______________
   ____

7. Were you alone when you started using?

   ___ Yes
   ___ No

8. During the course of this episode with whom did you associate?

   ___ Girlfriend/Boyfriend/Spouse
   ___ Friends
   ___ Acquaintances
   ___ Stranger
   ___ Other Relative (Specify)________
   ____

9. During this episode did you intentionally avoid any people?

   ___ Yes (Specify) ________________
   ___ No

10. During this episode did you intentionally avoid any places?

    ___ Yes (Specify) ________________
    ___ No

11. When were you arrested?

___ Morning (8:00 AM to Noon)
___ Afternoon (Noon to 4:00 PM)
___ Evening (4:00 PM to 8:00 PM)
___ Night (8:00 PM to Midnight)
___ Early Morn (Midnight to 8:00 AM)

12. What was your destination when arrested?________________________
____
____

13. Why did the police stop you?

___ Traffic Violation
___ Automobile Defect
___ Accident
___ Other (Specify) ______________
____

14. How many hours had passed since you started using?
____

15. What was your BAC, if applicable? ___
____

16. How much had you drunk? _______
____

17. Did you use other drugs also?

___ Yes
___ No

If yes, what substances were used and how much?

Substance	Amount

18. What is the most painful part of this episode?

___ Loss of Driving Privileges
___ Financial Costs
___ Telling Friends
___ Telling Family
___ ADEP Attendance
___ Feeling of Self-Disappointment

19. Name two activities that the use of alcohol or other drugs makes more enjoyable for you:

a. ______________________________
b. ______________________________

20. Name two activities that the use of alcohol or other substances makes more uncom- fortable for you:

a. ______________________________
b. ______________________________

21. What do you like most about yourself while using? ______________________
____
____

22. What do you like least about yourself while using? ______________________
____
____

23. What, if anything, would make you want to stop using? ______________
____
____
____
____

DECISIONMAKING SKILLS

People are not born with good decisionmaking skills. They are learned over time and are improved by practice. Good decisionmaking is not the result of superior intelligence but rather is the result of the willingness to learn the skills and to use them frequently.

Most of you are at a point in your life where you want to be independent and make decisions for yourself. That's good and to be expected. You don't particularly like parents telling you how to dress or what time to be home. You want to use your own judgement and make your own decisions. You would like to be free to choose.

It's sad, but true, that most of us do not make real decisions and do not exercise our freedom of choice, even when we have the chance. We go with the impulse or pressures of the moment. We go with the flow. We yield to peer pressure. We buy what is advertised. We follow the advice of friends. We do what we think will please someone else. We respond and react rather than really deciding.

What is good decisionmaking? Good decisionmaking is a process more than it is a certain decision or outcome. There is a five step process that constitutes good decisionmaking.

Step 1. Identify the problem or situation. Be as specific as possible

Step 2. Consider alternatives. There is typically more than one choice or course of action. What are they? Think of as many as possible.

Step 3. Evaluate the alternatives. This is a difficult step. We have to consider both facts and feelings. We have to predict the likely consequences of each alternative. We have to consider our values and our future goals.

Step 4. Choose an alternative and prepare a plan of action. A decision is made and needs to be carried out. A decision without a plan of action is more like daydreaming than deciding and acting.

Step 5. Evaluate the choice. Is the plan working satisfactorily? Did I overlook an important fact when I chose an alternative? Keep an open mind—don't be stubborn and defensive, if you made a mistake. If necessary, go back and choose one of the other alternatives. Or you might even go back to Step 1 and look at the problem or situation from another perspective and come up with other alternatives.

Good decisionmaking is not just an intellectual process, but it does involve thinking. It's not just processing information like a computer to get a conclusion. When you evaluate the alternatives, you need to deal with personal issues—Does that alternative feel right? Does it fit with my values? Does it go along with my goals for myself?

Using the decisionmaking process may be new or awkward for some. However, it's not as difficult or complicated as it may seem at first. You may even use some of the steps without realizing it. When you talk over a problem or situation with a friend, you sometimes use decision making skills. Other times when you talk over a problem, you may just be looking for understanding or sympathy. Or you may be looking for advice—having someone tell you what they would do based on their feelings, their values, and their goals. The point is that talking over a problem with a friend may use some or all of the steps in good decisionmaking. You can also use the decision making process on your own. The payoff for using decisionmaking skills is that problems become less problematic and you become more mature, self-confident, and independent.

Instructor Note: Organize an exercise to have students practice decision making skills. Pair students in groups of two, assigning one student the task of making a decision and assigning the other the task of listening, asking questions, and making sure that the decision making steps are followed. It is preferable if the pairs all deal with one or two common problems—this will facilitate later class discussion and learning. One possible problem/situation for the students to consider would be the following: Student X has saved $750 from odd jobs and birthday and Christmas gifts toward buying a used car. However, the kind of car Student X has been wanting costs $1,200 and there is also sales tax, license, insurance, repairs, and gas money to consider.

The instructor or class may develop other situation(s) for the exercise.

Students should next individually complete a worksheet on the following page to help them review and reassess their decision about substance use. This individual activity can occur during the class or may be given as a homework assignment, depending on the program structure and time available.

DECISIONMAKING WORKSHEET

(Name of Student) (Date)

STEP 1: Identify the situation.

(For example, in the past have I really decided to use or have I just reacted and followed the pressure of the moment or pressure of peers? How much do I use? Is that use causing problems—legal, school/job, finances, family, social, physical, emotional? Am I using more frequently or in larger amounts than I used to? What are the typical situations when I use?)

STEP 2: Consider alternatives.

(For example, continue as is, become chemically dependent, cut back in amount or frequency of use, stop use indefinitely.)

STEP 3: Evaluate each alternative.

(For example, how would each alternative fit with what I now know about alcohol and drugs? How would each alternative make me feel about myself? How does each alternative fit with my future goals and plans? What are the likely short-term and long-term consequences of each alternative?

Step 4: Choose an alternative and prepare a plan of action.

(Indicate the alternative you choose. However, a detailed plan of action does not have to be made at this time.)

Step 5: Evaluate the choice.

(This step should be done after you start the plan of action. This step does not have to be completed at this time.)

REFUSAL SKILLS

One reason that many young people and some adults use alcohol or drugs is that they have difficulty refusing an offer if it is presented. Many people feel pressured to use substances. Pressure occurs when someone encourages or tries to force you to do something. There are at least five types of pressure used when trying to persuade someone to use substances.

Instructor Note: Write on the board or flip chart the following types of pressure and explain each.

1. Pressure to try substances includes the simple offer.

   The simple offer involves someone offering you a drink, a pill, a snort, or any other substance as they might offer you a soda, a stick of chewing gum, or a piece of candy. For example, "Would you like a beer?"

2. Pressure to try substances includes the dare offer.

   The dare usually involves a challenge to your courage or sense of daring with statements like: "Go ahead, I dare you" or "What's the matter, are you scared to?"

3. Pressure to try substances includes the threat offer.

   The threat implies that you will lose something you value if you do not use. The loss could be anything you value, such as friendship or even the threat of harm to you if you do not participate. For example, "I won't be your friend if you don't try this."

4. Pressure to try substances includes the indirect offer.

   The indirect offer does not directly threaten you, but it implies a loss of stature if you don't participate. For example, "We're having a keg party. Be there or be square."

5. Pressure to try substances includes the internal offer.

   The internal offer appeals to your internal needs rather than external or social needs. For example, "Oh, you're feeling down today. I have some pills that will take care of that." This offer implies that substances will take care of your feelings and problems in living.

Sometimes the pressure will be a simple offer and will progress to a dare, threat, etc.

Instructor Note: Restate each type of pressure and ask students to indicate which type of pressure they most often face. Again restate the types of pressure and ask students to indicate which is the hardest to say "no" to.

There are good reasons for wanting to refuse offers of alcohol or drugs. Let's review some of the basic ones.

1. For adolescents, all alcohol or drug use is illegal except for the use of medications as prescribed by a physician.
2. Substance abuse interferes with natural development physically, emotionally and mentally. The interference involves both short term effects and long term effects.
3. Substance abuse is destructive to family relationships. Substance abuse by one family member negatively effects all family members.
4. Substance use can become a preoccupation and interfere with other interests and your ability to function.

Instructor Note: Ask the class for other reasons or more specific reasons.

Once you have begun using substances it is not easy to just stop and start saying "no". Even if you know in your mind that alcohol and drugs are a negative influence on your life and your future, it is not easy to change your behavior. However, there are certain skills and knowledge that can help you.

There are many different ways to refuse drug offers. Some of these techniques are:

1. "No thanks" Technique	"Would you like a joint?" "No, thanks."
2. Broken Record	Repeat the same phrase over and over. "Would you like a joint?" "No, thanks." "Come one!" "No, thanks." "Just try it, chicken!" "No, thanks."
3. Giving a Reason or Excuse	"How about a beer?"

	"No, thanks. I don't drink" or "No, thanks. I'm going to play ball in a little while."
4. Walk Away	"Would you like to smoke some marijuana?" Say "no" and walk away while you say it.
5. Cold Shoulder	"Hey! Do you want one of these pills?" Just ignore the person.
6. Changing the Subject	Start talking about something else. "Here. Do you want to cigarette?" "Come one. Let's get started with baseball practice."
7. Reversing the Pressure	Putting the pressure back on the person offering you the drug. "Do you want to smoke a joint with me?" "No, thanks. I thought you were my friend."
8. Avoiding the Situation	If you see or know of places where people often use drugs, stay away from those places. .
9. Strength in Numbers	Hang around with nonusers, especially where drug use is expected.

Instructor Note: Ask students for other examples.

Ask students to identify in their own mind the person who exerts the most pressure on them to use alcohol or drugs. Have the students visualize how they could counteract the pressure of the identified person. Encourage class sharing to the degree possible.

Have students complete the following two worksheets. Or the situations and questions on the worksheets could serve as a basis for class discussion.

WORKSHEET

Instructions: Read the following situation. Answer in writing the questions that follow.

You are at a party and you have decided you do not want to drink any alcohol. However, a friend offers you a drink.

1. Why might you have decided to not drink?

2. How would you refuse the offer of the drink?

3. What if your friend put a lot of pressure on you to drink?

WORKSHEET

Instructions: Join your assigned group. Read the following situation and discuss it in the group.

You are at a party with a group of friends. Many of them have been drinking. However, you have had little or nothing to drink. When it is time to leave, you realize the driver of the car in which you came had too much alcohol.

1. How could you stop this person from driving? ______________________________

   ____

   ____

   ____

   ____

2. How could you say "no" if this person told you everything was fine? ______________

   ____

   ____

   ____

   ____

3. What might happen if you said "yes" and allowed him to drive you home? __________

   ____

   ____

   ____

   ____

ALTERNATIVES TO USE

Reasons given for substance use are quite varied. Common ones include: be part of a group; to feel good or at least different than normal; to feel more socially confident and competent; to escape boredom; and many other plausible sounding reasons. And sometimes after drinking or using drugs over a period of time or when engaging in a particular set of activities, it is sometimes difficult to imagine doing things differently.

To compound matters, substance-free activities are sometimes limited for young people. However, if an individual is interested in finding substance-free activities, they are available and can be fun and rewarding. Substance-free activities will require more from the individual than does substance use, but they also will give more back. When people have trouble finding something that appeals to them, they should own the responsibility for their feelings and attitudes and work toward a solution. They may have an emotional or attitudinal problem or may have reached a point where substance use has become the focus of their activities.

It is not so much that the world is a boring place, it more often is that we have allowed ourselves to participate in negative thinking and that includes "I am bored", or "There's nothing to do".

Because we are all individuals, activities which appeal to one person may not to another. The point to remember is that we should remain as open to ideas as possible and exclude activities only after really considering or trying them. Remember that no one can take better care of you than yourself. Individuals should give themselves opportunities to grow, to use or develop skills, and to become involved in constructive activities.

Possible substance-free activities include:

1. Participation in organized sports, YMCA, neighborhood/youth centers.
2. Volunteering time to useful organizations such as hospitals, services to the blind, political activity, church groups, etc.

3. Trying a new hobby such as fishing, gardening, macrame, needlework, woodworking, model building, crossword puzzles, tropical fish, leather craft, musical instruments, paint-by-number, etc.

4. Physical fitness such as weight loss or muscle gain, running, jogging, lifting weights, etc.

5. Clubs such as cooking, reading, 4-H.

6. Learning something outside of school such as dance lessons, foreign languages, bird watching, astronomy, reading, etc.

7. Journal writing.

8. Theatre activities. These can include not only acting but also set building, lights, props, etc.

9. If unemployed, a part-time job.

The rewards offered by substance free activities, while possibly not as immediately exciting, are none the less more permanent and beneficial. Interests and skills learned now will add to your life for as long as you live. Continued substance use will teach you only how to become more dependent on alcohol and drugs.

Instructor Note: Ask students to offer other possible alternatives to substance use.

(Optional) Ask the class if anyone has developed a new skill or interest in an area that they previously avoided. Clarify the reasons why they had avoided such activities in the past and if those reasons were valid.

Ask each student to identify a new activity to try. Each student could identify an activity through completion of a worksheet. Those with similar interests or activities could further discuss or plan them.

CONCLUDING TASKS

Instructor Note: There are six tasks that need to be accomplished in the concluding phase of the program. (Sample forms can be found in Appendix I.)

- *Administering the post-test.*

- *Completing the course evaluation.*

  This evaluation does not have to be signed by the student. The students' opinions are sought to help improve future courses and make them as meaningful as possible.

- *Providing assessment recommendations to students and parents, if available.*

  This task should be done by the qualified professional who has conducted the interview and reviewed the student's questionnaires and worksheets. It may be done during the concluding phase of the program, if it has not been accomplished earlier. The major disadvantage to providing an assessment recommendation in the earlier phase of the program is that some students may be preoccupied with a recommendation for further services and lose interest in the program.

  The student and parent, if available, must be given a copy of the Notice of Assessment Recommendation.

- *Developing a Personal Plan .*

  This plan should be developed after the assessment recommendation has been provided so that any recommendation for further services can be considered by the student. Each student must complete a personal plan. The parent, if available, should also be encouraged to develop one.

- *Completing the Notice of Participation.*

  This written notice must be given to the student.

- *Notifying the Court and Department of Revenue.*

  Within one week after completion of the program, a copy of the Notice of Participation must be forwarded to the referring court and the Department of Revenue, if applicable. A copy of the Notice of Assessment Recommendation must also be forwarded to the referring court.

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—APPENDIX I SAMPLE FORMS

Information Notice to Student
Parent Acknowledgement
Student Registration
Student Information - Responsibilities, Rights, Grievances
Authorization for Parent Involvement
Consent to Release Information
Pre/Post Test
Student Survey
Family Member Questionnaire
Assessment Note
Course Evaluation
Notice of Participation
Notice of Assessment Recommendation
Personal Plan (Student)
Personal Plan (Family Member)
Screening Questionnaire

INFORMATION NOTICE TO STUDENT

Dear ____(Name of Student)____:

________(Name of Agency)________ is certified by the State of Missouri to provide an Alcohol and Drug Education Program. Completion of the program will assist you in meeting requirements that have been ordered by the court or that are necessary for driver's license reinstatement.

Classes will be held at ________(Address)________ on ________(Dates and Times)________.
________________(Directions as Needed)________________.

The fee is $____ and must be paid to successfully complete the program. Other requirements for successful completion are:

- arrive on time;
- be free of the influence of alcohol or drugs;
- attend sessions in their proper sequence (unless you request in advance and get approval to attend an alternate sequence);
- complete and sign all required forms;
- complete all class assignments and remain attentive in class; and
- cooperate with the instructor and other students.

When you register for the class, it would be helpful if you would bring the following information: court case number, drivers license number, date of offense, and date of court conviction. This information will make it easier to report your completion of the program to the court and the Department of Revenue, if your license has been revoked.

Participation by parents in the program is encouraged. For those students under 18 years of age, the participation of at least one parent or guardian is expected. There is no additional fee for family members. Family members are expected to abide by the class rules that apply to everyone. Parents should plan to attend the program on ________(Dates and Times)________. Enclosed is a notice that parents should complete and return regarding their attendance. This information helps us better plan and organize the class.

If you have any questions about the program or scheduling, please contact ________(Name)________ at (Telephone Number).

Sincerely,

This is a sample notice letter that meets requirements in 9 CSR 30-3.730(4). A program may adapt a notice to better meet its own needs, as long as it is in compliance with standards.

PARENT ACKNOWLEDGEMENT

I understand that I am strongly encouraged to attend portions of the alcohol and drug education program if my son or daughter is under the age of 18 and living at home. I understand that I am welcome to attend if my child is 18 or older.

Please check one of the following:

___ Yes, I plan to attend with my child on the dates and times indicated.

___ No, I do not plan to attend, but my child will.

___ I would like to attend, but am not available on the dates and times indicated. Please schedule us for another class so that we can participate. I can be reached at __(Telephone Number)__ during the hours of ____(Time)____.

Note to Parent: If your son or daughter is under the age of 18 and is being sent to the Alcohol and Drug Education Program due to an offense regarding alcohol, then you must either: (1) complete and return this form or (2) accompany your child to registration at the start of the class. Otherwise, your child cannot be admitted to the program.

________________________________ Name of Student

____________ Age of Student

________________________________ Signature of Parent/Guardian

____________ Date

Please complete and return this form by ________________ to:
(Date)

111

STUDENT REGISTRATION

Name ______________________________ Telephone Number ( ) ____________
(Last) (First) (M.I.)

Address ____
(Street) (City) (Zip Code)

Age ________________ Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Other (specify) ____________

Marital status: ☐ Never married ☐ Married ☐ Divorced/Separated

Are you attending school? ☐ Yes ☐ No If yes, what grade or year? ____________
If no, what was the highest grade you completed? ______

Are you employed? ☐ Yes ☐ No If yes, how many hours per week? ____________

Do you live with your parent or guardian? ☐ Yes ☐ No

What is the name of your parent(s) or guardian? ______________________________

What was the offense that resulted in your attending this program?

☐ alcohol related traffic offense (DWI or BAC)

☐ possession or use of alcohol while operating a motor vehicle

☐ misrepresentation of a driver's license

☐ possession or use of marijuana (first offense with 35 grams or less or marijuana)

☐ possession or use of a controlled substance (other than small amount of marijuana, as above)

☐ possession or use of alcohol (first offense)

☐ other (Specify) ______________________________

Is your driver's license revoked? ☐ Yes ☐ No

Did you take a breathalyzer or other test related to your offense? ☐ Yes ☐ No
If yes, what was your BAC? ______ %

What court or office sent you to this program? ______________________________

Have you had a previous conviction related to the possession or use of alcohol or drugs? ☐ Yes ☐ No
If yes, please identify the following:

DATE	OFFENSE	RESULT

______________________________ ______________________________
Signature of Student Date

STUDENT RESPONSIBILITIES

In order to receive credit for successfully completing the program, a student must

- Arrive on time
- Be free of the influence of all mind altering substances
- Attend sessions in their proper sequence (unless you request in advance and get approval to attend an alternate sequence).
- Complete and sign all required forms
- Complete all class assignments and remain attentive in class
- Cooperate with the instructor and other students
- Pay all fees

STUDENT RIGHTS

All students will

- Be treated with respect and dignity and will be free of any type of abuse.
- Receive services irregardless of race, sex, creed, marital status, national origin, or handicap.
- Have records kept confidential. Any information about your participation in ADEP can only be released when there is written consent or a court order. Records may be audited for the purpose of ADEP certification. Confidentiality does not extend to a medical emergency, child abuse, or crime committed on the premises or against staff. Confidentiality is assured under the following state and federal laws and regulations: 9 CSR 30-3.700, 42 USC 290, and 42 CFR Part 2.

GRIEVANCE PROCEDURE

A student who thinks that these rules and rights have not been fairly applied should ____. Any student who is not able to resolve their grievance with the program may make a written, signed complaint to the Department of Mental Health, Division of Alcohol and Drug Abuse, P.O. Box 687, Jefferson City, MO 65102.

AUTHORIZATION FOR PARENT INVOLVEMENT IN THE ALCOHOL AND DRUG EDUCATION PROGRAM (ADEP)

I, ______________________________, authorize ______________________________
(Name of Student) (Name of Program)

to involve ______________________________ in the program by:
(Name of Parent)

- completing paperwork and countersigning forms, as necessary
- having them attend the class, as scheduled
- informing them of any further service recommendations

The purpose of this disclosure is to promote family participation and communication in the Alcohol and Drug Education Program (ADEP).

This consent will expire on ______________________________.
(Specify Date of Event)

I understand that I may revoke this consent except to the extent that the program has already acted on it.

______________________________ ____________________
(Signature of Student) (Date)

CONSENT TO RELEASE INFORMATION

I, ________________________________, authorize ________________________________
(Name of Student) (Name of Program)

Initial Box

☐ TO RELEASE TO ________________________________
(Name of Court or Probation Office)

- Notice of program completion, including attendance and any violations of program rules.
- Notice of any assessment recommendations regarding further services.

The purpose of this disclosure is to provide information so that the court can make appropriate disposition of my alcohol or drug related offense.

Initial Box

☐ TO RELEASE TO THE MISSOURI DEPARTMENT OF REVENUE

- Notice of successful program completion.

The purpose of this disclosure is to provide information so that the Department of Revenue can make appropriate disposition of my drivers license suspension or revocation. I understand that I can revoke my consent to release information to the Department of Revenue except to the extent that the program has already acted on it.

This consent will expire on ________________________________.
(Specify Date or Event)

________________________________ ____________________
(Signature of Student) (Date)

________________________________ ____________________
(Signature of Parent/Guardian, if Applicable) (Date)

PRE/POST TEST

Do not mark on test sheet. Please mark only on the answer sheet.

Please answer the following questions either true or false.

T F 1. Alcohol is the most commonly abused drug in America.

T F 2. Traffic accidents in which alcohol is a factor kill more 15 to 24 year olds than any other single cause.

T F 3. Alcohol is a sedative which speeds up a person's reflexes.

T F 4. To be chemically dependent or alcoholic, one has to have abused alcohol/drugs for years.

T F 5. Young people who have a parent who is chemically dependent are less likely to become dependent themselves, because they know first-hand the problems involved.

T F 6. Fetal Alcohol Syndrome (FAS) and alcohol-related birth defects occur only when the mothers drink large amounts on a regular basis during the pregnancy.

T F 7. Marijuana use has been proven to be harmless both physically and psychologically.

T F 8. The active ingredient in marijuana, THC, is detectable in the body at least a week after use.

T F 9. Marijuana use has little or no effect on memory and thinking.

T F 10. Sexual development for both sexes is complicated by the use of marijuana.

T F 11. Cocaine and crack can be addictive.

T F 12. Cocaine can cause death with few if any preceeding symptoms.

T F 13. AIDS can be contracted by the sharing of a needle for intravaneous injection of drugs.

T F 14. AIDS can be contracted by touching, sneezing, or using the same towels.

T F 15. Hallucinogen users tend to share the same visual experiences.

T F 16. No completely safe mind altering substance has been found.

T F 17. There is much more alcohol in a drink of whiskey than there is in a can of beer.

T F 18. Two people, one weighing 150 pounds and the other 100 pounds, will have the same Blood Alcohol Concentration if they drink the same amount in the same time.

T F 19. Alcohol is eliminated from the body primarily by the liver.

T F 20. It is impossible to die from drinking too much alcohol at one time.

T F 21. Alcoholism is recognized as a disease by medical and health organizations.

T F 22. Alcoholism can be inherited.

T F 23. Substance abuse by one family member tends to be a problem for all other members of that family.

T F 24. Alcoholism/substance dependency is readily recognized by the individual and the family.

T F 25. Drinking alcohol or using other drugs can improve sexual ability.

T F 26. It is impossible to become an alcoholic if one drinks only beer.

Please answer the following questions with either A, B, C, or D.

27. The psychoactive effects of a substance depends on:

    A. the dose
    B. the person's body
    C. the method of use.
    D. all of the above

28. Alcoholism strikes one in:

    A. 10 drinkers
    B. 15 drinkers
    C. 20 drinkers
    D. 25 drinkers

29. Fetal Alcohol Syndrome (FAS) symptoms are:

    A. temporary
    B. permanent
    C. cured by medicine
    D. none of the above

30. All of the following drugs have recognized medical uses except:

    A. stimulants
    B. THC
    C. tranquilizers
    D. barbiturates

31. 80 proof whiskey is what percent alcohol:

    A. 20
    B. 40
    C. 80
    D. none of the above

32. Moderate marijuana use impairs:

    A. Reflexes
    B. Thinking
    C. Judgement
    D. All of the above

33. If a BAC of 0.10% is proof of intoxication, impairment begins at:

    A. 0.09%
    B. 0.07%
    C. 0.05%
    D. 0.03%

34. Alcohol-related traffic accidents account for what percent of all traffic accidents?

    A. 20 percent
    B. 35 percent
    C. 50 percent
    D. 65 percent

35. Those who are most likely to develop trouble with alcohol or other substances are those who:

    A. Begin use in early adolescence
    B. Begin use in early adulthood
    C. Begin use in middle adulthood
    D. No difference

36. The most dangerous drug combination is:

    A. LSD and marijuana
    B. Speed and marijuana
    C. Alcohol and downers
    D. PCP and speed

37. Evidence shows that heavy marijuana use can cause:

    A. Memory impairment
    B. Lung damage
    C. Increased risk of cancer
    D. All of the above

38. A woman who drinks during pregnancy:

    A. Always gains too much weight
    B. Will become an alcoholic
    C. Will have an alcoholic baby
    D. Runs the risk of having a baby with Fetal Alcohol Syndrome

ANSWER SHEET

Name ______________________________ Date ________________

Pre-Test or Post-Test
(Circle One)

1. T F
2. T F
3. T F
4. T F
5. T F
6. T F
7. T F
8. T F
9. T F
10. T F
11. T F
12. T F
13. T F
14. T F
15. T F
16. T F
17. T F
18. T F
19. T F
20. T F
21. T F
22. T F
23. T F
24. T F
25. T F
26. T F
27. A B C D
28. A B C D
29. A B C D
30. A B C D
31. A B C D
32. A B C D
33. A B C D
34. A B C D
35. A B C D
36. A B C D
37. A B C D
38. A B C D

PRE/POST TEST SCORING GUIDE

(For Instructor Use Only)

For scoring ease, fold this page along the vertical lines and place the edge next to the corresponding column.

1.	T
2.	T
3.	F
4.	F
5.	F
6.	F
7.	F
8.	T
9.	F
10.	T
11.	T
12	T
13	T
14.	F
15.	F
16.	T
17.	F
18	F
19.	T
20.	F
21.	T
22.	T
23.	T
24.	F
25.	F
26.	F
27.	D
28.	A
29.	B
30.	B
31.	B
32.	D
33.	D
34.	C
35.	A
36.	C
37.	D
38.	D

STUDENT SURVEY

Student Name ______________________________ Date _________________________

Please answer all of the following questions about your experiences with alcohol and other drugs. Read each question carefully and mark the circle corresponding to the answer that is right for you. This questionnaire will be reviewed only by the staff of the Alcohol and Drug Education Program.

1. On how many occasions (if any) have you had alcohol to drink... (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

IF YOU HAVE NOT HAD ANY BEER, WINE, OR LIQUOR IN THE LAST TWELVE MONTHS, GO TO QUESTION 8.

2. When you used alcohol in the last year, how often did you use it in each of the following situations? (Mark one circle for each line.)

	Not at all	A few of the times	Some of the times	Most of the times	Every time
a. When you were alone	○	○	○	○	○
b. With just 1 or 2 other people	○	○	○	○	○
c. At a party	○	○	○	○	○
d. In presence of your date/spouse	○	○	○	○	○
e. In presence of people over 30	○	○	○	○	○
f. During the day (before 4:00 p.m.)	○	○	○	○	○
g. At your home/apartment/dorm	○	○	○	○	○
h. At school	○	○	○	○	○
i. In a car	○	○	○	○	○

3. What have been the most important reasons for your drinking alcoholic beverages? (Mark all that apply.)

○ To experiment—to see what it's like
○ To relax or relieve tension
○ To feel good or get high
○ To seek deeper insights and understanding
○ To have a good time with my friends
○ To fit in with a group I like
○ To get away from my problems or troubles
○ Because of boredom, nothing else to do
○ Because of anger or frustration
○ To get through the day
○ To increase the effects of some other drug(s)
○ To decrease the effects of some other drug(s)
○ To get to sleep
○ Because it tastes good
○ Because I am "hooked"—I feel I have to drink

4. When you drink alcoholic beverages, how high do you usually get?

○ Not at all high
○ A little high
○ Moderately high
○ Very high

5. When you drink alcoholic beverages, how long do you usually stay high?

○ Usually don't get high
○ One to two hours
○ Three to six hours
○ Seven to 24 hours
○ More than 24 hours

6. Have you ever tried to stop using alcoholic beverages and found that you couldn't stop?

○ Yes
○ No

7. When (if ever) did you first drink enough to feel drunk or very high?

○ Never got drunk
○ Age 12 or earlier
○ Age 13 or 14
○ Age 15
○ Age 16
○ Age 17
○ Age 18
○ Age 19 or older

8. On how many occasions (if any) have you used marijuana or hashish... (Mark one circle for each line).

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

IF YOU HAVE NOT USED MARIJUANA OR HASHISH IN THE LAST TWELVE MONTHS GO TO QUESTION 21.

9. How old were you when you first used marijuana or hashish?

○ 12 or earlier
○ age 13 or 14
○ age 15
○ age 16
○ age 17
○ age 18
○ age 19 or older

10. When you used marijuana or hashish during the last year, how often did you use it in each of the following situations. (Mark one circle for each line.)

	Not at all	A few of the times	Some of the times	Most of the times	Every time
a. When you were alone	○	○	○	○	○
b. With just 1 or 2 other people	○	○	○	○	○
c. At a party	○	○	○	○	○
d. In presence of your date/spouse	○	○	○	○	○
e. In presence of people over 30	○	○	○	○	○
f. During the day (before 4:00 pm)	○	○	○	○	○
g. At your home/apartment/dorm	○	○	○	○	○
h. At school	○	○	○	○	○
i. In a car	○	○	○	○	○

11. How many of the times when you used marijuana or hashish during the last year did you use it along with alcohol—that is, so that their effects overlapped?

Not at all	A few of the times	Some of the times	Most of the times	Every time
○	○	○	○	○

12. What have been the most important reasons for your using marijuana or hashish? (Mark all that apply.)

○ To experiment—to see what it's like
○ To relax or relieve tension
○ To feel good or get high
○ To seek deeper insights and understanding
○ To have a good time with my friends
○ To fit in with a group I like
○ To get away from my problems or troubles
○ Because of boredom, nothing else to do
○ Because of anger or frustration
○ To get through the day
○ To increase the effects of some other drug(s)
○ To decrease the effects of some other drug(s)
○ Because I am "hooked"—I feel I have to use?

13. When you use marijuana or hashish how high do you usually get?

○ Not at all high
○ A little high
○ Moderately high
○ Very high

14. When you use marijuana or hashish how long do you usually stay high?

○ Usually don't get high
○ One to two hours
○ Three to six hours
○ Seven to 24 hours
○ More than 24 hours

15. During the LAST MONTH, about how many marijuana cigarettes (joints, reefers), or the equivalent, did you smoke a day, on the average? (If you shared them with other people, count only the amount YOU smoked.)

○ None
○ Less than 1 a day
○ 1 a day
○ 2 - 3 a day
○ 4 - 6 a day
○ 7 - 10 a day
○ 11 or more a day

16. Have you ever tried to stop using marijuana or hashish and found that you couldn't stop?

○ Yes
○ No

17. Thinking back over your whole life, has there ever been a period when you used marijuana or hashish on a daily, or almost daily, basis for at least a month?

○ No—GO TO QUESTION 32
○ Yes

18. How old were you when you first smoked marijuana or hashish that frequently?

○ age 12 or earlier
○ age 13 or 14
○ age 15
○ age 16
○ age 17
○ age 18
○ age 19 or older

19. How recently did you used marijuana or hashish on a daily, or almost daily, basis for at least a month?

○ During the past month
○ 2 months ago
○ 3 to 9 months ago
○ About 1 year ago
○ About 2 years ago
○ 3 or more years ago

20. Over your whole lifetime, during how many months have you used marijuana or hashish on a daily or near-daily basis?

○ Less than 3 months
○ 3 to 9 months
○ About 1 year
○ About 1 and 1/2 years
○ About 2 years
○ About 3 to 5 years
○ 6 to 9 years
○ 10 or more years

21. On how many occasions (if any) have you taken cocaine, which is sometimes called coke, crack, or rock... (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

22. On how many occasions (if any) have you taken LSD, which is sometimes called acid... (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

23. On how many occasions (if any) have you taken psychedelics other than LSD, which would include PCP, mescalin, etc.. (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

24. On how many occasions (if any) have you taken amphetamines on your own—that is, without a doctor telling you to take them... (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

25. On how many occasions (if any) have you taken sedatives (which are sometimes called downers, seconal, barbiturates) on your own—that is, without a doctor telling you take them...(Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

26. On how many occasions (if any) have you taken tranquilizers (such as Librium or Valium) on your own—that is, without a doctor telling you to take them...(Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

27. On how many occasions (if any) have you taken heroin, which is sometimes called smack, horse, skag... (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

28. On how many occasions (if any) have you taken narcotics other than heroin, such as opium, demoral, morphine, on your own—that is, without a doctor telling you to take them... (Mark one circle for each line.

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	○	○	○	○	○	○	○
b. during the last 12 months?	○	○	○	○	○	○	○
c. during the last 30 days?	○	○	○	○	○	○	○

29. On how many occasions (if any) have you used inhalants, such as gasoline, glue, aerosals... (Mark one circle for each line.)

	0 Occasions	1-2 Occasions	3-5 Occasions	6-9 Occasions	10-19 Occasions	20-39 Occasions	40 or More
a. in your lifetime?	0	0	0	0	0	0	0
b. during the last 12 months?	0	0	0	0	0	0	0
c. during the last 30 days?	0	0	0	0	0	0	0

30. How old were you when you used the following drugs?

	Never used	12 or earlier	Age 13 or 14	Age 15	Age 16	Age 17	Age 18	19 or older
a. cocaine	0	0	0	0	0	0	0	0
b.LSD	0	0	0	0	0	0	0	0
c. psychedelics other than LSD	0	0	0	0	0	0	0	0
d. amphetamines	0	0	0	0	0	0	0	0
e. sedatives	0	0	0	0	0	0	0	0
f. tranquilizers	0	0	0	0	0	0	0	0
g. heroin	0	0	0	0	0	0	0	0
h. narcotics other than heroin	0	0	0	0	0	0	0	0

31. How difficult would it be for you to get each of the following substances?

	Impossible	Very Difficult	Fairly Difficult	Fairly Easy	Very Easy
a. alcohol	0	0	0	0	0
b. marijuana	0	0	0	0	0
c. cocaine	0	0	0	0	0
d. LSD	0	0	0	0	0
e. psychedelics other than LSD	0	0	0	0	0
f. amphetamines	0	0	0	0	0
g. sedatives	0	0	0	0	0
h. tranquilizers	0	0	0	0	0
i. heroin	0	0	0	0	0
j. narcotics other than heroin	0	0	0	0	0

32. Over the past 12 months, about how often have you gone to parties?

0 Not at all
0 Once a month
0 2 - 3 times
0 About 1 a week
0 2 or 3 times a week
0 Over 3 times a week

IF YOU HAVE NOT GONE TO PARTIES OVER THE PAST 12 MONTHS, GO TO QUESTION 34.

33. Now think about the parties you went to in the past 12 months. How often did...

	Not at all	A few of the times	Some of the times	Most of the times	Every time
a. Someone get high on alcohol?	0	0	0	0	0
b. Most people get high on alcohol?	0	0	0	0	0
c. You get high on alcohol?	0	0	0	0	0
d. You feel pressure to drink alcohol?	0	0	0	0	0
e. You feel pressure to get high?	0	0	0	0	0
f. Someone get high on marijuana?	0	0	0	0	0
g. Most people get high on marijuana?	0	0	0	0	0
h. You get high on marijuana?	0	0	0	0	0
i. You feel pressure to use marijuana?	0	0	0	0	0
j. Someone get high on other drugs?	0	0	0	0	0
k. You get high on other drugs?	0	0	0	0	0

34. Within the last 12 months how many times if any, have you received a ticket (or been stopped and warned for moving violations such as speeding, running a stop light, or improper passing?

0 None—Go TO QUESTION 36
0 Once.
0 Twice
0 Three times
0 Four or more times

35. How many of these tickets or warnings occurred after you were...

	None	One	Two	Three	Four +
a. Drinking alcoholic beverages?	0	0	0	0	0
b. Smoking marijuana or hashish?	0	0	0	0	0
c. Using other illegal drugs	0	0	0	0	0

36. We are interested in any accidents which occurred while you were driving a car, truck, or motorcycle. ("Accidents" means a collision involving property damage or personal injury—not bumps or scratches in parking lots.)

0 None—STOP, SURVEY IS COMPLETED.
0 One
0 Two
0 Three
0 Four or more

37. How many of these accidents occurred after you were...

	None	One	Two	Three	Four +
a. Drinking alcoholic beverages?	0	0	0	0	0
b. Smoking marijuana or hashish?	0	0	0	0	0
c. Using other illegal drugs?	0	0	0	0	0

STUDENT SURVEY

Comparative Data From A Nationwide Sample of High School Seniors

This information is taken from "National Trends in Drug Use and Related Factors Among American High School Students and Young Adults, 1975-1986". DHHS Publication No. (ADM) 87-1535. 1987 printing. All percentages have been rounded.

- On how many occasions (if any) have you had alcohol to drink.

In your lifetime?	90% report use
During the last 12 months?	85% report use
During the last 30 days?	65% report use

- When you drink alcoholic beverages, how high do you ususally get?

Not at all high	15%
A little high	35%
Moderately high	40%
Very high	10%

- When you drink alcoholic beverages, how long do you usually stay high?

Usually don't get high	20%
One to two hours	40%
Three to six hours	35%
Seven or more hours	5%

- When (if ever) did you first drink enough to feel drunk or very high?

Never got drunk	30%
Age 12 or younger	5%
Age 13 or 14	15%
Age 15	20%
Age 16	15%
Age 17	10%
Age 18	5%

- On how many occasions (if any) have you used marijuana or hashish...

In your lifetime?	50% report use
During the last 12 months?	40% report use
During the last 30 days?	25% report use

- How old were you when you first used marijuana or hashish?

Age 12 or younger	3%
Age 13 or 14	10%
Age 15	10%
Age 16	10%
Age 17	10%
Age 18	5%

- When you use marijuana or hashish how high do you usually get?

Not at all high	5%
A little high	30%
Moderatley high	40%
Very high	25%

- When you use marijuana or hashish how long do you usually stay high?

Usually don't get high	10%
One or two hours	50%
Three to six hours	25%
Seven hours or more	15%

- During the last month about how many marijuana cigarettes did you smoke a day on the average?

  4% of high school seniors report daily use of marijuana in the past month.

- Thinking back over your whole life, has there ever been a period when you used marijuana on a daily, or almost daily, basis for at least a month?

  15% report daily use for a month or longer.

- How old were you when you first smoked marijuana that frequently?

Age 12 or younger	1%
Age 13 or 14	4%
Age 15	4%
Age 16	3%
Age 17	2%
Age 18	1%

- How recently did you use marijuana or hashish on a daily, or almost daily, basis for at least a month?

During the past month	4%
2 months ago	2%
3 to 9 months ago	3%
About 1 year ago	2%
About 2 years ago	2%
3 or more years ago	2%

- Over your whole lifetime, during how many months have you used marijuana or hashish on a daily or near-daily basis?

Less than 3 months	5%
3 to 9 months	3%
About 1 year	2%
About 1 and 1/2 years	1%
About 2 years	1%
About 3 to 5 years	2%
6 to 9 years	1%

- On how many occasions (if any) have you taken cocaine, which is sometimes called coke, crack, rock...

In your lifetime?	17% report use
During the last 12 months?	6% report use
During the last 30 day?	6% report use

- On how many occasions (if any) have you taken LSD, which is sometimes called acid...

In your lifetime?	7% report use
During the last 12 months?	3% report use
During the last 30 days?	2% report use

- On how many ocasions (if any) have you taken psychedelics other than LSD, which would include PCP, mescalin, etc...

In your lifetime?	5% report use
During the last 12 months?	1% report use
During the last 30 days?	1% report use

- On how many occasions (if any) have you taken amphetamines on your own—that is without a doctor telling you to take them...

In your lifetime?	23% report use
During the last 12 months?	8% report use
During the last 30 days?	5% report use

- On how many occasions (if any) have you taken sedatives (which are sometimes called downers, seconal, barbiturates) on your own—that is, without a doctor telling you to take them...

In your lifetime?	10% report use
During the last 12 months?	3% report use
During the last 30 days?	2% report use

- On how many occasions (if any) have you taken tranquilizers (such as Librium or Valium) on your own—that is without a doctor telling you to take them...

In your lifetime?	11% report use
During the last 12 monhts?	4% report use
During the last 30 days?	2% report use

- On how many occasions (if any) have you taken heroin (which is sometimes called smack, horse, skag)...

In your lifetime?	1% report use
During the last 12 months?	.3% report use
During the last 30 days?	.2% report use

- On how many occasions (if any) have you taken narcotics other than heroin (such as demoral, morphine) on your own—that is, without a doctor telling you to take them...

In your lifetime?	9% report use
During the last 12 months?	3% report use
During the last 30 days?	2% report use

- On how many occasions (if any) have you used inhalants (such as gasoline, glue, aerosols)...

In your lifetime?	20% report use
In the last 12 monhts	6% report use
In the last 30 days	3% report use

- How old were you when you used the following drugs?

	PERCENT							
	Never Used	12 or Earlier	Age 13-14	Age 15	Age 16	Age 17	Age 18	19 or Older
Cocaine	83	–	1	2	4	5	5	–
LSD	93	–	–	1	2	2	2	–
Psychedelics other than LSD	95	–	1	1	1	1	1	–
Amphetamines	77	–	4	7	6	4	2	–
Sedatives	90	–	2	3	2	2	1	–
Tranquilizers	90	–	1	2	3	2	2	–
Heroin	99	–	–	–	–	–	–	–
Narcotics other than Heroin	91	–	1	2	2	2	2	–
Inhalants	84	2	3	3	3	3	2	–

- How difficult would it be for you to get each of the following substances?

	Fairly Easy Very Easy
Marijuana	85%
Cocaine	50%
LSD	30%
Psychedelics other than LSD	25%
Amphetamines	65%
Sedatives	50%
Tranquilizers	50%
Heroin	20%
Narcotics other than Heroin	30%

FAMILY MEMBER QUESTIONNAIRE

Date ____________________

Name of Family Member ______________________________

Address ____

Telephone Number ____________________________________

Name of Student ______________________________________

Your Relationship to Student ____________________________

Instructions: Please answer the following questions to the best of your ability by placing a check (✓) next to the response you choose or by writing in the space provided. In these questions, the word "substance" refers to alcohol or drugs or both. The word "student" refers to the individual required to participate in this course.

1. Do you live with the student at the present time?

   ___ Yes
   ___ No

2. How long has the student been using substances?

   ___ 1 year or less
   ___ 2 years
   ___ 3 years
   ___ 4 years or longer

3. How frequently does the student use substances?

   ___ Several times a week
   ___ Weekly
   ___ Monthly
   ___ Seldom

4. Which of the following substances does the student use?

   ___ Alcohol
   ___ Marijuana
   ___ Cocaine
   ___ Downers/Sedatives
   ___ Uppers/Stimulants
   ___ Hallucinogens
   ___ Narcotics
   ___ Other

5. Has the student ever come home clearly intoxicated or high?

   ___ Yes
   ___ No
   ___ Uncertain

6. Has the student come home intoxicated or high more than once?

   ___ Yes
   ___ No
   ___ Uncertain

7. Has the student's substance use interfered with family relationships?

   ___ Yes
   ___ No

8. Has the student's substance use interfered with school performance?

   ___ Yes
   ___ No

9. Has the student used substances at school or gone to school under the influence?

   ___ Yes
   ___ No
   ___ Uncertain

10. Has the student changed friends because of substance use?

___ Yes
___ No

11. Has the student continued to increase his or her use of substances?

___ Yes
___ No
___ Uncertain

12. Has the student's substance use caused a loss of interests, activities, or hobbies?

___ Yes
___ No

13. Has the student ever suffered a physical problem or injury because of substance use?

___ Yes
___ No

If yes, please specify ________________
____
____

14. Has the student promised to stop substance use but been unable to do so?

___ Yes
___ No

15. Has the student stolen money from family members in order to obtain alcohol or drugs?

___ Yes
___ No

If yes, please specify ________________
____
____

16. Has the student ever received counseling or other help for substance use?

___ Yes
___ No

If yes, please specify ________________
____
____

17. Has the student ever received counseling or other help for any emotional or behavioral problem?

___ Yes
___ No

If yes, please specify ________________
____
____

18. Has the student ever been in trouble with the law (other than the incident which lead to participation in this course)?

___ Yes
___ No

If yes, please specify ________________
____
____

19. Has the student ever been suspended from school?

___ Yes
___ No

If yes, please specify ________________
____
____

20. My use of alcoholic beverages is best described as?

___ Never
___ Occasional Use
___ Frequent Use
___ Possibly a Problem

21. Others have told me that I drink too much?

___ Yes
___ No

22. My spouse's use of alcoholic beverages is best described as?

___ Never
___ Occasional Use
___ Frequent Use
___ Possibly a Problem
___ Not Applicable

23. Others have told my spouse that he or she drinks too much?

___ Yes
___ No

24. Are you concerned about the student's substance use?

___ Yes
___ No
___ Uncertain

25. Would you like to talk with someone regarding the student's behavior or your family situation?

___ Yes
___ No

If yes, telephone number and best time to call: ______________________________
____
____

Family Member Questionnaire
Scoring Guidelines

Tabulate the number of YES answers to questions 6-16.

A YES answer to 1 - 2 questions is an indication of probable substance abuse.

A YES answer to 3 - 4 questions is an indication of possible substance dependency.

A YES answer to 5 or more questions is an indicator of probable substance dependency.

Responses to other questions provide additional family and background information to be considered in the assessment.

ASSESSMENT NOTE

Name of Student: ______________________________

Date of Interview: ______________ Length of Interview: ______________

Source of Data (Check all that apply)

- ☐ Individual Interview
- ☐ Small Group Interview
- ☐ Screening Questionnaire
- ☐ Student Survey
- ☐ Motivations Worksheet
- ☐ Decision Making Worksheet
- ☐ Family Member Questionnaire
- ☐ Family Member Interview
- ☐ Other (Specify) ______________

Result of Screening Questionnaire:

*Substance Use History (Type, Amount, Frequency, Changes in Use Pattern):

Effects of Substances in Life Areas:

Legal

School/Job

Finances

Family

Social

Physical

Emotional

Summary of Findings:

Recommendation:

______________________________ ______________

(Signature of Qualified Professional) (Date)

*May refer to Student Survey, if one was completed

COURSE EVALUATION

NAME OF ADEP ____________________ DATE ____________________

INSTRUCTOR(S) ____________________

____

Please help us to improve our program by completing this course evaluation. Place in each box the number which best describes your opinion: (1) Excellent, (2) Good, (3) Fair, (4) Poor

Additional comments are also appreciated.

Instructor

☐ Exercised appropriate class control
☐ Related with class
☐ Knowledge of subject
☐ Responded to class needs

Comments: ____________________

____

____

Course Curriculum

☐ Information about alcohol and drugs
☐ Substance use and driving
☐ Recognizing chemical dependency
☐ Effects of substance abuse on the family
☐ Personal decisions about substance use

Comments: ____________________

____

____

Films

☐ Quality
☐ Appropriateness
☐ Number (1-right amount, 2-too few, 3-too many)

Comments: ____________________

____

____

Assessment and Referral

☐ The counselor listened to me.
☐ The counselor was skilled and knowledgeable.
☐ The counselor understood me.

Comments: ____________________

____

____

____

Guest Speakers (if applicable)

☐ Appropriate topic
☐ Speaker's ability

Comments: ____________________

____

____

Facilities

☐ Parking
☐ Comfortable, suitable facility

Comments: ____________________

____

____

Suggestions for Improvement

____

____

____

Signed (optional) ____________________

NOTICE OF PARTICIPATION
ALCOHOL AND DRUG
EDUCATION PROGRAM (ADEP)

Name of Student (Last, First, M.I.)

____

Date of Birth ________ *Driver's License No. ________

Court of Jurisdiction ________ *Case Number ________

*Date of Offense ________ *Date of Conviction ________

The above student has:

☐ successfully completed the program.

☐ failed to complete the program.

Reason for failure, where applicable: ________

____

____

Name of Program ________ Certificate # ________

Signature of Program Administrator ________ Date ________

* To be completed, if available .

INSTRUCTIONS

(1) Original for program records
(2) Offender is provided Copy 2
(3) Copy 3 is forwarded to the Dept. of Revenue, if appplicable
(4) Copy 4 is forwarded to the court

This form is available in a four-page NCR format and can be purchased from the Missouri Department of Health at a bulk printing rate. An ADEP may instead make its own local printing arrangements. When the Department of Revenue needs to be notified, copy 3 should be sent to: Department of Revenue, P.O. Box 200, Jefferson City, Missouri 65102.

NOTICE OF ASSESSMENT RECOMMENDATION
ALCOHOL AND DRUG OFFENDER EDUCATION PROGRAMS

Name of Student ______________________________
(Last) (First) (M.I.)

Name of Program ______________________________

Assessment Recommendation

☐ No further services ☐ Residential services ☐ Outpatient services

☐ Self-Help groups ☐ Other (Specify) ______________

Comments: ______________________________

____

____

Reason for recommendation: ______________________________

____

____

______________________________ ______________
Signature of Qualified Professional Date

STUDENT ACKNOWLEDGEMENT

I have been informed of the assessment recommendation and have received a list of area resources, if further services were recommended. I understand that I can successfully complete the program without receiving further services. I understand that I am not obligated to utilize any particular service provider. My signature indicates only that I have been informed of the assessment recommendations.

______________________________ ______________
Signature of Student Date

……

INSTRUCTIONS FOR PROGRAM

(1) Original for program records
(2) Copy 2 is provided to the student
(3) Copy 3 is provided to the parent/guardian, if applicable
(4) Copy 4 is forwarded to the court

This form is available in a four-page NCR format and can be purchased from Missouri Department of Mental Health at a bulk printing rate. An ADEP may instead make its own local printing arrangements.

PERSONAL PLAN FOR STUDENT

Student Name ______________________________ Date ____________________

Describe your attitude toward substance use before this course.

Has your attitude changed in any way? If so, how?

Describe your personal plan to avoid another alcohol or drug-related offense.

How do you know your plan will work?

PERSONAL PLAN FOR FAMILY MEMBER

(Name)

(Date)

Considering all that I have learned about alcohol and drugs and their effects on the family, I plan to do the following to help avoid further substance use problems in my family:

Actions toward ADEP student

Actions toward the rest of the family

Actions toward self

SCREENING QUESTIONNAIRE

Name ______________________ Date ________________

DIRECTIONS. This questionnaire asks about you and your experiences, including those with alcohol and other drugs. Some questions ask how often certain things have happened. Others ask how much you agree with a statement. Please read each question carefully. Put a mark in the space (_X_) under the answer that is right for you. Please answer every question.

PART I. For questions in Part I, please mark only one of the following answers: Never, Once or Twice, Sometimes, Often.

HOW OFTEN HAVE YOU USED ALCOHOL OR OTHER DRUGS:	Never	Once or Twice	Some-times	Often
1. At home	(__)	(__)	(__)	(__)
2. At places on the street where adults hang around	(__)	(__)	(__)	(__)
3. With older friends or relatives	(__)	(__)	(__)	(__)
4. At the homes of friends or relatives	(__)	(__)	(__)	(__)
5. At school activities, such as dances or football games	(__)	(__)	(__)	(__)
6. At work	(__)	(__)	(__)	(__)
7. When skipping school	(__)	(__)	(__)	(__)
8. To enjoy music or colors, or feel more creative	(__)	(__)	(__)	(__)
9. While skydiving from an airplane	(__)	(__)	(__)	(__)

HOW OFTEN HAVE YOU	Never	Once or Twice	Some-times	Often
10. Made excuses to your parents about your alcohol or drug use	(__)	(__)	(__)	(__)
11. Obtained drugs from a dealer	(__)	(__)	(__)	(__)
12. Used alcohol or drugs secretly, so nobody would know you were using	(__)	(__)	(__)	(__)
13. Made excuses to teachers about your alcohol or drug use	(__)	(__)	(__)	(__)

	Never	Once or Twice	Some-times	Often
14. Been upset about other people talking about your using or drinking	☐	☐	☐	☐
15. Acquired alcohol or drugs from a traffic cop	☐	☐	☐	☐

WHEN USING ALCOHOL OR OTHER DRUGS, HOW OFTEN HAVE YOU:	Never	Once or Twice	Some-times	Often
16. Spilled things, bumped into things, fallen down, or had trouble walking around	☐	☐	☐	☐
17. Seen, felt, or heard things that were not really there	☐	☐	☐	☐
18. Spent money on things you wouldn't normally buy	☐	☐	☐	☐
19. Found out things you said or did while using or drinking that you did not remember	☐	☐	☐	☐

IN ORDER TO GET OR PAY FOR ALCOHOL OR OTHER DRUGS, HOW OFTEN HAVE YOU:	Never	Once or Twice	Some-times	Often
20. Sold drugs	☐	☐	☐	☐
21. Tricked people by using counterfeit or fake money	☐	☐	☐	☐

PART II. For questions in Part II, please mark either yes or no.

PERSONAL EXPERIENCES:	Yes	No
22. I am always courteous, even to people who are disagreeable.	☐	☐
23. There have been occasions when I took advantage of someone.	☐	☐
24. There have been times when I felt like rebelling against people in authority even though I knew they were right..	☐	☐
25. I am always willing to admit it when I make a mistake.	☐	☐
26. There have been occasions when I felt like smashing things.	☐	☐

SCREENING QUESTIONNAIRE INFORMATION SHEET

The Screening Questionnaire is a 26 item self-report instrument for use with adolescents (12-18 years old) suspected of abusing chemicals. It functions as a screening or pre-assessment. There are 18 items regarding Substance Use Problem Severity, 5 items regarding Defensiveness (faking-good), and 3 items regarding Infrequency (faking-bad).

The readability level of the Screening Questionnaire is estimated at grade 4. There is no time limit for completing the test. The questionnaire can be completed in 10 minutes by most teenagers.

Students should be encouraged by the instructor to approach the questionnaire in an honest and straightforward manner, and the instructor is obliged to inform students of the purpose of the questionnaire.

It is advisable that the instructor refrain from discussing specific test items with students. Occasionally, students may not understand the meaning of a particular item and will ask for clarification. The instructor should avoid giving clarifying information and simply instruct the student to make the best choice possible. However, if it appears that the student is unable to adequately read the Screening Questionnaire, then it can be administered by reading aloud the items.

After students complete the test, program staff need to review their answers to make sure that items were not accidentally skipped. The Defensiveness scale and the Infrequency scale indicate whether the questionnaire is a valid measure.

SCREENING QUESTIONNAIRE SCORING FORM

----------Defensiveness Response----------

Item	Yes	No
22.	_____	_____
25.	_____	_____

COUNT _____ (X2) = ☐ _____ (X1) = ☐

Item	Yes	No
23.	_____	_____
24.	_____	_____
26.	_____	_____

COUNT _____ (X1) = ☐ _____ (X2) = ☐

TOTAL _____ + _____ + _____ + _____ = ☐ D

--------------Infrequency Response--------------

	Never	Once or Twice	Sometimes	Often		Never	Once or Twice	Sometimes	Often
9.	_____	_____	_____	_____	21.	_____	_____	_____	_____
15.	_____	_____	_____	_____					

COUNT Never _____ (X1) = ☐ + Once or Twice _____ (X2) = ☐ + Sometimes _____ (X3) = ☐ + Often _____ (X4) = ☐ = ☐ I

INFREQUENCY SCORING CODE

Defensiveness (Faking Good) Scoring Rules
Warning Flag Raw Score
8-10

Infrequency (Faking Bad) Scoring Rules
Warning Flag Raw Score
4-12

Interpretation

A test should be considered invalid if at least one warning flag has been triggered. A warning score on both Defensiveness and Infrequency suggests random or inattentive responding.

A warning score on Defensiveness suggests that the individual is presenting oneself in a socially desirable way and may be denying or hiding personal problems. Because it is common for teenagers to see oneself in a favorable light, an extreme score on this scale is needed to trigger the warning flag.

A warning score on Infrequency suggests faking-bad response tendencies by exaggerating claims of chemical use problem severity. Since the three Infrequency items represent very unlikely events, minimal endorsement of any of them triggers the warning flag.

SCREENING QUESTIONNAIRE SCORING FORM

Name _______________________________ Age ________ Sex ________

--------------------Problem Severity Response--------------------

	Never	Once or Twice	Sometimes	Often		Never	Once or Twice	Sometimes	Often
1.	_____	_____	_____	_____	11.	_____	_____	_____	_____
2.	_____	_____	_____	_____	12.	_____	_____	_____	_____
3.	_____	_____	_____	_____	13.	_____	_____	_____	_____
4.	_____	_____	_____	_____	14.	_____	_____	_____	_____
5.	_____	_____	_____	_____	16.	_____	_____	_____	_____
6.	_____	_____	_____	_____	17.	_____	_____	_____	_____
7.	_____	_____	_____	_____	18.	_____	_____	_____	_____
8.	_____	_____	_____	_____	19.	_____	_____	_____	_____
10.	_____	_____	_____	_____	20.	_____	_____	_____	_____

COUNT Never _____ (X1) = ☐ + Once or Twice _____ (X2) = ☐ + Sometimes _____ (X3) = ☐ + Often _____ (X4) = ☐ = ☐ PS TOTAL

PROBLEM SEVERITY SCORING RULES

	Red Light Raw Score	Green Light Raw Score Dim	Green Light Raw Score Bright
Males			
12-15 years old	18-30	31-41	41-72
16-18 years old	18-34	35-45	46-72
Females			
12-15 years old	18-29	30-40	41-72
16-18 years old	18-33	34-44	45-72

INTERPRETATION

Red Light means that no further assessment referral is recommended. This score range is characteristic of a normal teenager.

Green Light indicates a need for further assessment referral. The Dim light score range is characteristic of abusive chemical use. Approximately 80 percent of a Minnesota group of teenagers with scores in this range were referred for chemical dependency treatment. The Bright light score is indicative of very abusive or dependent use of chemicals. Approximately 95 percent of a Minnesota group of teenagers with scores in this range were referred for chemical dependency treatment.

—APPENDIX II PROGRAM OPERATIONS

Disruptive Student
Incident Report
Small Group Interview Method
Individual Assessment Interview
Recommendation
Area Resources (Sample Format)
Confidentiality Provisions
Summary of Record-Keeping Requirements

DISRUPTIVE STUDENT

Appropriate interchange between instructor and students increases student involvement in the class and should be encouraged. However, if the interchange is not appropriate for whatever reason, it detracts from the educational process and should not be allowed.

Expectations concerning the conduct of both students and family members are to be addressed early in the program and are to include what actions the instructor must take and what the consequenses of those actions will be if anyone demonstrates inappropriate behavior, i.e. becomes argumentative, sleeps during class, uses any substances prior or during class, or returns late from break. Consequences could include: inform referral source, loss of registration fee, start course over, removal from class.

Instructors, sometimes in the hope of enlisting the support of certain class members, may allow those members special privileges or may allow the entire class too much latitude in the beginning, hoping to regain control sometime later in the program. These are almost always questionable tactics. If control over the entire class, or any segment of it, is lost, it becomes extremely difficult to regain control. It is far easier to "loosen-up" than it is to "tighten-up". Class members almost never respect anyone of whom they can take advantage.

Individual programs should develop written policy and procedure for dealing with such contingencies as: class members who appear substance impaired either at the beginning of the program or after a break, class members who are argumentative or hostile, class members who sleep or talk during class or engage any other activity which detracts from the program. Written procedures are particularly important when several staff members are involved with the program.

If substance use can be confirmed or if there is some other flagarant violation of program rules, the ADEP should dismiss the student and notify the court of non-completion. If the staff member is unable to clearly establish that a class member is substance impaired (i.e. no breath odor of alcohol and the staff member did not observe the individual engaging in substance use), one approach would be for the suspected individual to be informed that his attitude and behavior, if indicated, is disruptive to the class. The student or family member would then be instructed to leave with the understanding that they must reschedule the class if they intend to complete the course. If substance use cannot be confirmed, it might be advisable to allow the student to re-enroll at a future date, paying only a nominal re-instatement or re-scheduling fee. A re-scheduling fee in the $5 to $10 range is considered reasonable. A re-scheduling fee may also be charged if a student does not show for a scheduled class, unless advance approval and arrangements have been made.

Class participants whose behavior is disruptive and who are not substance impaired should be offered the opportunity to bring their behavior in line with program expectations. If they refuse, then the offenders must be required to leave. The instructor's primary concerns are the educational benefits and the safety of the class, not one or more troublesome students. Those ejected should not receive credit for completing the course.

An incident report must be completed any time a student is removed from the class or anytime the safety of the class or instructor is compromised. (See the following page for a sample Incident Report.) The report must be reviewed and countersigned by the program administrator. The administrator shall make the final disposition of the incident.

All incidents involving a disruptive student are challenging to the instructor/professional. Should a disruptive student/family member refuse to leave and if they pose a threat to the class or the program personnel, the instructor, with the safety his class and himself as the prime consideration, must follow the dictates of the situation, i.e. if the disruptive participant appears to be intent on hurting someone, the class should be dismissed and when possible, the authorities summoned. In any case the disruptive student should be made to know that his behavior will be reported to the courts, to the probation officer or to whomever is concerned.

Impaired participants who are allowed to remain will very quickly erode the program's reputation and its effectiveness. The other class participants will probably be aware of any substance use and will base not only their future behavior but their opinion of the program on how well the ADEP follows its own guidelines.

One substance impaired class participant not adequately and promptly dealt with will, in all probability, be reflected in the subsequent attitude and behavior of other class members. However, the reverse is also true, impaired students or family members expediently and effectively handled will help build the program's reputation and make classes easier to manage.

INCIDENT REPORT

(Program) ____________________ (Date of Incident) ____________________

(Student) ____________________ (Staff Involved) ____________________

Description of the Behavior or Incident:

Action Taken:

(Signature of Staff Member) (Date)

****

TO BE COMPLETED BY PROGRAM ADMINISTRATOR

Additional Information:

Final Disposition:

(Signature of Administrator) (Date)

SMALL GROUP INTERVIEW METHOD

The small group interview can be a valuable tool in determining the extent of an individual's involvement with alcohol or drugs. It can be one method of conducting an individualized assessment as required by 9 CSR 30-3.760(9B).

Interviews are most effective when the qualified counselor-to-student ratio is no more than one to six. The length of the small group interview will vary depending on the number of students. The interview should be done in the middle stages of ADEP. If the ADEP consists of three sessions, a small group interview would be suited for the early part of the second session. It is acceptable if students take part in the group interview regardless of score on screening instruments. Inclusion of all students can lend balance to the group and may result in better class logistics, particularly if the class is small in number and the instuctor functions as the qualified professional.

Many times a person's natural defenses may hinder an accurate assessment. To best achieve an honest assessment of the impact of substance use on the student's life, a relaxed tone is desirable. In the small group, words such as "alcoholic" or "drug addict" can be avoided to lessen the students' defenses. If necessary, the term "harmful involvement" may be used because it is less threatening.

The small group process may be facilitated by the group sitting in a circle, facing inward. If there is a chalkboard or flipchart, the qualified professional writes the major life areas on it. He may instead choose to distribute a list of the life areas to the students. The life areas should include: Legal, School/Job, Finances, Family, Social, Physical, Emotional/Self-Esteem, Sexual (Optional), and Spiritual (Optional).

The staff member tells the students that the goal of the interview is to determine how substance use may be affecting these life areas for each of us.

The qualified professional begins by introducing himself and telling as much about himself as is necessary to establish a feeling of honesty and sharing. (The staff member may or may not make reference to his own drinking or drug history, whether or not he is recovering, or other information pertinent to the process.) He should then ask if someone in the group would voluntarily begin the process. Often someone wants to go first, but if no one offers, the staff member chooses someone. That person then begins by stating how much he uses (or did use prior to the time when he received the citation) and how that use has affected all of the seven life areas.

Sample questions for small group process can include:

1. Legal: Name all legal difficulties associated with substance use, e.g. alcohol or drug related traffic offenses, speeding, stealing, fighting, drunk and disorderly.
2. School/Job: Has the use of substances ever caused you difficulty either at school or on the job, e.g. reduced performance, caused absenteeism, confronted by supervisor/school authorities?
3. Finances: Do you spend a disproportionate amount of your money on alcohol or other drugs? Have you stolen from family or friends in order to purchase substances?
4. Family: Does substance use cause friction between you and family members? Does your drinking or drug use cause problems between other family members, i.e. mother and father? Have you run away from home? Have you been kicked out of the house?
5. Social: Does your use of alcohol or drugs cause problems between you and friends? Have you started "running" with a different crowd because the other one did not use as much as you wanted to? Do nearly all of your friends drink or use drugs frequently? Do you feel awkward in social situations unless you can use substances?
6. Physical: Have you suffered from physical problems related to alcohol or drugs (other than hangover), e.g. disruption of sleep or eating patterns, blackouts, injuries?
7. Emotional/Self-esteem: Do you think less of yourself because you drink or do drugs? Do you think you are a better or more confident person because of your substance use? Have you done things which you find embarassing or shame producing while drinking or using? Have you been discouraged to the point of considering suicide?

(Optional) Sexual: Have your decisions about partners, time, place or activity ever been affected by drinking or using? Has sexual performance ever been compromised by alcohol or drug use (inability to achieve or maintain erection for men, failure to lubricate for women)?

(Optional) Spiritual: Has the use of alcohol or other substances interfered with how you view the universe and your place in it? Do you feel more alienated or divided from others as a result of drinking and using?

Some interviewers prefer to rely on memory, writing down as much as they are able immediately after the interview. They feel that the prescense of the note pad tends to inhibit openness. Others prefer to take notes during this part of the process, realizing that they may not be able to remember all they should. They attempt to overcome any student apprehension about the note taking by making comments, such as—"There will be more said in the group than I can remember and I will need to take notes", "I don't want to lose or forget any important information", "You are welcome to look at my notes", or "No notes will be given to parents, the court, or anyone else". The size of the group may also influence the decision to take or not to take notes.

After each student in the group has gone through all of the life areas and described how the use of alcohol or drugs has affected each one, the counselor, in private, should make an assessment based on the interview and other questionnaires and worksheets. The counselor needs to determine to what extent, if any, the student demonstrates substance abuse or dependency. Based on this assessment, an appropriate recommendation for services needs to be developed, where indicated.

Small group interview sessions can best be facilitated when each group has a certain amount of privacy. If the ADEP class has more than six students needing an individual assessment, the interviews may need to be accomplished at different times. However, if there are other qualified professionals present, then small group interviews can be accomplished simultaneously. A qualified professional must not have the responsibility for more than six students at one time. It might be possible for the same person to hold more than one small group interview during the same evening or day. This would require careful program planning and the assistance of another staff member or instructor.

Students who score in the problem range on the Screening Questionnaire need to have not only an assessment of how substance use is affecting life areas but also an assessment of substance use patterns. The substance use pattern may be discussed in the small group interview, or the patterns be assessed by means of the Student Survey. (See Student Survey on page I-11 in Appendix I.)

INDIVIDUAL ASSESSMENT INTERVIEW

The logistics of an individual or "one-on-one" assessment interview can vary considerably and still be effective and adhere to the standards. The time taken for the interview cannot be counted as part of the ten hours of education which each student is required to receive.

Only the students who score in the problem area on the screening questionnaire must receive a more complete assessment interview. The instructor, based on his observations, may also require a student to receive an individualized assessment. The student is not required to pay any additional fee for the assessment, as it is built into the standard ADEP fee.

While individual assessment interviews may be time and labor intensive, some programs may prefer them over the small group interview process. Both approaches have strengths and weaknesses. Whichever approach is used, it is preferable to conduct the assessment in the early to middle stages of the ADEP course

The individual interview should take place in a private setting. The appropriate length of time for the individual interview will vary depending on the style of the interviewer and whether the substance use history is taken during the interview itself or previously through a questionnaire. It does save time to have the history completed prior to the interview with the qualified professional then referencing it during the interview. (See Student Survey on page I-11 in Appendix I.)

The qualified professional determines if there is harmful involvement with alcohol or drugs in the following major life areas of the student: legal, job/school, finances, family, social, physical and emotional.

The qualified professional shall combine the information gathered from the interview with the results of the screening questionnaire, parent questionnaire, and any other class worksheets or observations to reach a conclusion about whether or not the student presents substance abuse or dependency. The counselor shall develop an appropriate recommendation, e.g. no further services, outpatient treatment, residential treatment, or participation in a self-help group such as Alcoholics Anonymous or Narcotics Anonymous.

RECOMMENDATION

The student will have recommendations presented and explained to him. Ideally, this would be done near the close of the program. If the student is given a recommendation for further services at an earlier time, he may lose interest in the program, discount what is said, or even become disruptive.

The process of informing the student of their assessment and recommendation, again, can be accomplished in a variety of ways depending on number of personnel available, space, and number of students. A class of 20 students certainly will have more logistical problems than one of seven or eight.

It is possible to make recommendations to the class as a whole. The instructor or qualified professional could present each student with a written summary or explanation for the recommendation and offer to discuss matters further after class. Another method would be to take aside (to another room or to the hallway) all those with similar recommendations, leaving the others to work on an assignment, watch a film/video,etc. As the different groups receive their assessment recommendation, they would then be asked to develop their personal plan. (See page I-26 in Appendix I.)

Another method would be for each student and parent to have an exit interview during which the assessment and any recommendation is discussed. This method may be the most desirable but presents more timing and logistical considerations, particularly with a larger class.

Each student who receives a recommendation for further services must be given a directory of all service providers in the area. The directory or listing must include the name of the program, type of service(s) provided, availability of a sliding fee scale, telephone number and address. The directory must include the where and when of local AA and NA, and may also include Alanon and Alateen meetings.

All students who receive a recommendation for further services sign off that they have been given a recommendation, have received a list of resources, and understand that they are not required to obtain any further services from the person or agency who provided the ADEP. The Notice of Assessment Recommendation form clearly states that the student's signature means that he has received information, not that he necessarily agrees with the recommendation.

AREA RESOURCES

Residential Programs

Name:
Address:
Phone:
* Fees:

Name:
Address:
Phone:
Fees:

Outpatient Programs

Name:
Address:
Phone:
** Type Service:

Name:
Address:
Phone:
Type Service:

Self-Help Meetings***

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

* Fees: General information should be included, but exact charges do not need to be listed. General information could include such data as - "Based on ability to pay" or "Insurance coverage" or "Individual payment plans" as the case may be.

** Type of Service: This could include notations such as "by appointment", "intensive evening program", or other special characteristics of the program.

*** Self-Help Meetings: This listing must include Alcoholics Anonymous and Narcotics Anonymous meetings, as available. Each meeting should be identified as "open" or "closed". Alanon, Naranon, and Alateen meetings may be included.

This is a sample format for listing local referral resources. A statewide listing of certified treatment programs which provide services to adolescents can be obtained from: Certification and Treatment Section, Division of Alcohol and Drug Abuse, P.O. Box 687, Jefferson City, MO 65102. The listing identifies both publicly funded and private programs.

CONFIDENTIALITY PROVISIONS

Confidentiality of records is required in the ADEP certification standards, and federal confidentiality regulations (42 CFR Part 2) are applicable. Confidentiality provisions and regulations are applicable because ADEPs provide assessment and referral and because many of the organizations sponsoring ADEPs receive direct or indirect federal assistance. A sample consent form is contained on page I-6 in Appendix I.

In the ideal situation, the following steps related to confidentiality issues will occur: The student receives the scheduling and information notice (see page I-1 in Appendix I) and gives the return portion to the parent to complete. The parent forwards the return portion to the program (see Parent Acknowledgement on page I-2 in Appendix I). The form indicates expected parent participation and also serves as parent consent, where needed. The student and parent both arrive for the first session and fully complete all consent forms and other registration and initial paperwork. The student thus has given written consent for parent participation and consent for release of information to the court and to the Department of Revenue, when there has been a license revocation. The parent must also sign the consent for the court and Department of Revenue, if the student is under the age of 18 and is atttending the ADEP due to an alcohol offense or alcohol abuse. Under other conditions, the student's written consent is adequate. When the ADEP sends the Notice of Assessment Recommendation to the court, the notice should have a redisclosure statement stamped on it (42 CFR Part 2 - 2.32).

The above steps fulfill the basic confidentiality requirements including:

- Students must give written consent before parents can be involved in ADEP. A completed Parent Involvement Form will fulfill this requirement (see page I-5 in Appendix I). (42 CFR Part 2-2.14)

- Students must give written consent for the release of information to the court or the Department of Revenue. (42 CFR Part 2 - 2.2 and 2.14)

- If the student is under the age of 18 and attending due to an alcohol offense or alcohol abuse, a parent must consent to services. A completed Parent Acknowledgement will fulfill this requirement of state statute. (Section 431.061 RSMo 1986)

- If the student is under the age of 18 and attending due to an alcohol offense or alcohol abuse, both the student and the parent must provide written consent before information can be released to a third party, such as the court or Department of Revenue. (42 CFR Part 2 - 2.14)

Actual events do not always occur as planned. The following questions and answers are intended to address other situations that may occasionally occur in the operation of ADEPs:

1. What should an ADEP do if the parent does not accompany the student to the first session and has not returned the Parent Acknowledgement section of the scheduling letter?

   The program should encourage a student of any age who is living at home to have one or both of their parents accompany them to the first session. A problem faces the ADEP only if the student is under the age of 18 and is attending due to an alcohol offense or alcohol abuse. Missouri law does not authorize a minor to independently obtain services due to an alcohol problem. The ADEP should refuse admission under these conditions. The student may begin the program at another time if a parent completes the Parent Acknowledgement.

   If the minor student with an alcohol offense comes alone and has a completed Parent Acknowledgement, the student may be admitted. However, the student must be informed that successful completion and credit with the court and Department of Revenue will occur only if the student has the parent to countersign the consent to release information to the court and/or Department of Revenue.

2. What should an ADEP do if a student refuses to sign the form authorizing parent involvement?

   The staff member should explain the reasons for and benefits of parent participation, but the student may refuse. The parental role is essential only if the student is under the age of 18 and has an alcohol offense. In these cases, proper admission would involve a signed Parent Acknowledgement. The parent would also need to countersign the form to release information to the court or Department of Revenue before successful completion could occur.

3. What should an ADEP do if the parent of a student under the age of 18 with an alcohol offense does not countersign the form to release information the court or Department of Revenue?

   The ADEP cannot notify the court or Department of Revenue of either successful or unsuccessful completion without the written consent of both the minor and the parent, unless other special circumstances exist. Notification could be made if the initial court order for ADEP included a provision for reporting completion of the program and any assessment recommendation. Along with the order, the court should also issue a subpoena to the ADEP. If the court has not specifically ordered reporting or disclosure, the program may apply to the court for a hearing to authorize release of client information. (See 42 CFR Part 2 - 2.64)

4. What should an ADEP do if a student wants to revoke his consent to release information to the court, parent, or Department of Revenue?

   Consent to release information to the court cannot be revoked by the student (or parent) once given. Consent by the student to involve a parent may be revoked; however, the revocation would constitute unsuccessful completion if the student were a minor with an alcohol offense. Consent to release information to the Department of Revenue technically can be revoked at any time, although it would be of no benefit to the student to do so.

SUMMARY OF RECORD-KEEPING REQUIREMENTS IN ALCOHOL AND DRUG OFFENDER EDUCATION PROGRAMS

Personnel Records

For each instructor, qualified professional, and administrator, there must be a personnel file containing at least:

* • College Transcript
* • Resume Indicating Past Employment Experience
* • Statement of Eligibility (license status, alcohol/drug offenses, absence of illicit use or substance abuse)
- Annual Job Performance Evaluation
* • Documentation of Continuing Education

Student Records

** • Copy of Notice to Students
- Student Registration
- Consent to Release Information
* • Parent Acknowledgement
* • Authorization for Parent Involvement
- Screening Questionnaire
- Pre/Post Test Answer Sheets (Scored)
* • Student Survey
* • Family Member Questionnaire
* • Assessment Note
- Personal Plan (Student)
* • Personal Plan (Family Member)
* • Notice of Assessment Recommendation
- Notice of Participation

Administrative Records

- Attendance Records for Each Session
- Receipts for Student Fees
- Course Evaluations by Students
- Policy and Procedure
  - — Individualized assessment methods
  - — Method by which students and parents, if applicable, are informed of assessment recommendation
  - — Grievance Procedure
  - * — Table of Organization
  - * — Roster of guest speakers and summary statement of each of their duties/tasks
  - * — Procedures for the recruitment, selection, training, supervision, dismissal and compensation of guest speakers

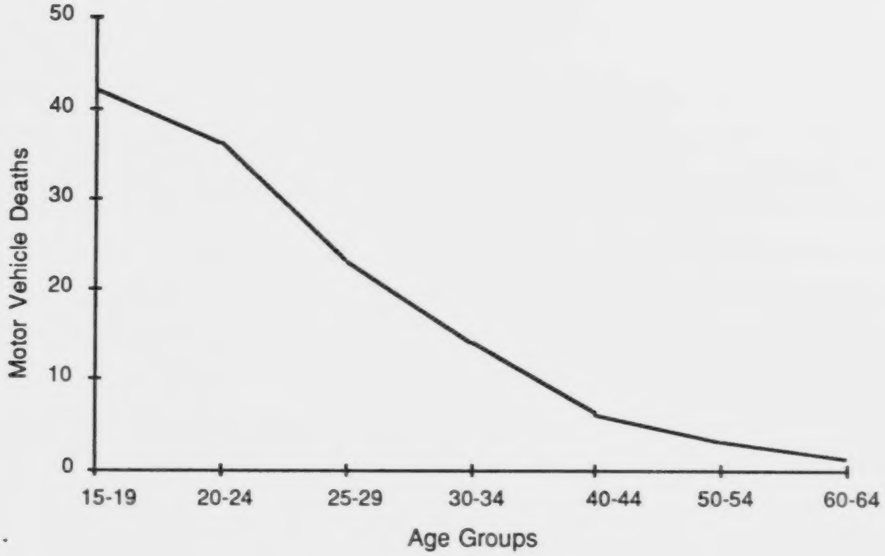
* As Applicable, As Available, or Optional. Personnel records so designated must be directly submitted to the Division of Alcohol and Drug Abuse.

**A copy of the notice/letter to the student may be used to show the scheduled dates of attendance. The program may use another method of documentation in the student record to show the dates of attendance, as required in 9 CSR 30-3.770(4).

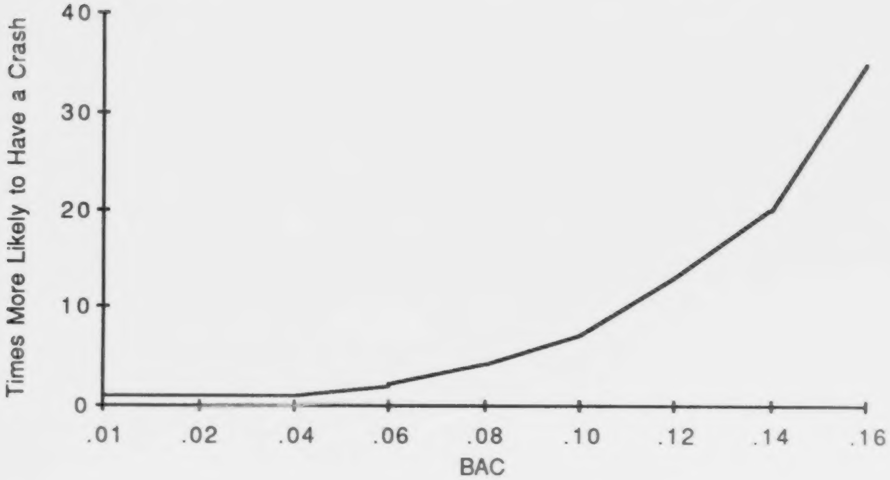
—APPENDIX III RESOURCE MATERIAL

Graph - Motor Vehicle Deaths
Graph - Probability of Crash
Drugs of Abuse
Physical Effects of Drug Abuse
Glossary of Drug Slang
BAC Chart
Drinking Myths
Effects of Marijuana on the Body
AIDS Testing Sites
Family V-Chart
Children of Alcoholics Screening Test (C.A.S.T.)
Roles of Children of Alcoholics
Levels of Substance Use by Adolescents
Substance Dependence and Abuse (DSM III - R)
Barriers to Treatment
Film Resources
Film Reviews

MOTOR VEHICLE DEATHS AS A PERCENT OF ALL DEATHS FOR SELECTED AGE GROUPS



PROBABILITY OF A CRASH



DRUGS OF ABUSE

CATEGORY	Drugs	Medical Uses	Physical	Psychological	Effects in Hours	Possible Effects	Effects of Overdose	Withdrawal Symptoms
CANNABIS	Marijuana	Under Investigation	Unknown	Moderate	2 - 4	Euphoria, relaxed inhibitions, increase in heart and pulse rate, reddening of the eyes, increased appetite, disoriented behavior	Anxiety, paranoia, loss of concentration, slower movements, time distortion	Insomnia, hyperactivity and decreased appetite occasionally reported
	Tetrahydrocannabinol							
	Hashish	None						
	Hash Oil							
DEPRESSANTS	Alcohol	None	High	High	1 -12	Slurred speech, disorientation, drunken behavior, loss of coordination, impaired reactions	Shallow respiration, cold and clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
	Barbiturates	Anesthetic, Anti-convulsant, Sedative, Hypnotic	High - Moderate	High - Moderate	1 - 16			
	Methaqualone	Sedative, Hypnotic	High	High	4 - 8			
	Tranquilizers	Anti-anxiety, Anti-convulsant, Sedative	Moderate to Low	Moderate	4 - 8			
STIMULANTS	Cocaine	Local anesthetic	Possible	High	1/2 - 2	Increased alertness, excitation, euphoria, increase in pulse rate and blood pressure, insomnia, loss of appetite, pupils dilated	Agitation, increase in body temperature, hallucinations, convulsions, possible death, tremors	Apathy, long periods of sleep, irritability, depression
	Amphetamines	Hyperactivity, narcolepsy			2 - 4			
	Nicotine	None	High	High			Agitation, increase in pulse rate and blood pressure, loss of appetite, insomnia	
	Caffeine		Low	Low				
HALLUCINOGENS	LSD	None	None	Degree Unknown	8 - 12	Illusions and hallucinations, poor perception of time and distance, increased pulse and blood pressure, numbness in extremities, increased pulse and blood pressure, flashbacks	Drug effects becoming longer and more intense, psychosis	Withdrawal symptoms not reported
	Mescaline and Peyote							
	Phencyclidine	Veterinary anesthetic	Unknown	High	Variable			
	Psilocybin - Psilocin	None	None	Degree Unknown	6			
INHALANTS	Nitrous Oxide	Anesthetic	Possible	Unknown	Up to 1/2 hour	Excitement, euphoria, giddiness, loss of inhibitions, aggressiveness, delusions, depression, drowsiness, headache, nausea	Loss of memory, confusion, unsteady gait, erratic heartbeat and pulse, possible death	Insomnia, decreased appetite, depression, irritability, headache
	Butyl Nitrite	None						
	Amyl Nitrite	Heart stimulant						
	Chlorohydrocarbons	None						
	Hydrocarbons	None						
NARCOTICS	Opium	Antidiarrheal, pain relief	High	High	3 - 6	Euphoria, drowsiness, respiratory depression, constricted pupils, nausea, vomiting, constipation, slurred speech, reduced hunger, sex- aggression drives	Slow and shallow breathing, clammy skin, convulsions, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite, irritability, tremors, panic, chills and sweating, cramps, nausea
	Morphine	Pain relief, cough medicine						
	Codeine		Moderate	Moderate				
	Heroin	Under investigation	High	High				
	Methadone	Heroin substitute, pain relief			12 - 24			

PHYSICAL EFFECTS OF DRUGS OF ABUSE

	MARIJUANA	AMPHETAMINES	COCAINE	SEDATIVES	LSD	NARCOTICS	INHALANTS
Agitation (Shaky)			•	•	•	•	
Loss of Appetite		•	•		•		
Increase of Appetite (Sugar)	•						
Lack of Coordination	•			•			
Drowsiness	•			•		•	
Drunken Appearance (no smell of alcohol)				•			•
Blank Expression							•
Flushed Face		•			•		
Pale Face					•		
Bloodshot Eyes	•					•	
Dilated Pupils		•	•		•		
Pin Pointed Pupils						•	
Dry (Cracked) Mouth	•	•					
Moist Mouth					•		
Sweating		•			•	•	
Thick Slurred Speech				•			•
Rapid Speech		•					
Talkative	•	•					
Restlessness		•					
Frequent Urination	•	•					

GLOSSARY OF DRUG SLANG

Acid - a street term for LSD.

Angel Dust - one of the many street names for phencyclidine (PCP).

Bad Trip - the term used to describe a panic reaction or other seriously disturbing psychological reaction to a psychoactive drug such as marijuana or LSD.

Barb(s) - street slang for barbiturates.

Beans or Black Beauties - street slang for black capsules usually containing amphetamines.

Bernice - cocaine.

Blue Devils - "Amytal" (brand of amobarbital, Eli Lilly and Company) capsules.

Boot - to inject a drug directly into a vein.

Bummer - a street term for a bad experience—a bad trip—from a drug.

Burned Out - a street term for a drug user who has used habitually to the extent that intelligence and motivation are noticeably diminished.

Cactus - term occasionally used for the peyote cactus which has hallucinogenic properties similar to those of LSD.

Candy - Barbiturates

Cartwheels - amphetamine sulfate (round, white, double-scored tablets)

Coke - slang for cocaine.

Cold Turkey - Sudden drug withdrawal.

Coming Down - the gradual disappearance of a drug's psychic effects as the drug wears off.

Co-Pilots - amphetamine tablets.

Crack - slang for cocaine in a smokable form.

Crank - slang term for amphetamines.

Crash - to come down from the effects of a drug, sometimes with accompanying extreme fatigue or depression.

Crystal - a street term for injectable amphetamine, i.e. amphetamine crystals that can be dissolved for intravenous injection.

Cut - a street term for the process of adulterating a drug to increase its bulk (and the dealer's profit), or for the material that is used to adulterate the drug. Most street drugs are cut and may contain ten percent or less of the alleged material.

Dexies - "Dexedrine" (brand of dextroamphetamine sulfate, Smith Kline & French Laboratories) tablets.

Dime Bag - a ten-dollar purchase of narcotics.

Dollies - "Dolphine" (brand of methadone hydrochloride, Eli Lilly and Company) tablets.

Dope - any form of illicit drug, although most often applied currently to marijuana, as in, "Are you smoking any dope?"

Double Trouble - "Tuinal" (brand of amobarbital sodium and secobarbital sodium, Eli Lilly and Company) capsules.

Downer - a barbiturate or other sedative; also sometimes used to describe a depressing or unhappy experience, as in, "It was a downer."

Dust - cocaine.

Eight-ball - an eighth of an ounce of amphetamine.

Gee-head - paregoric abuser.

Gluey - young glue sniffer.

Gold Dust - cocaine.

Goofballs - barbiturates.

Grass - marijuana.

Greenies - green, heart-shaped tablets of dextroamphetamine sulfate and amobarbital.

H - heroin.

Harry - heroin.

Hash - street term for hashish, the hardened resin of cannabis sativa, which may contain as high as 10 percent content.

Hearts - "Benzedrine" or "Dexedrine" (brands of amphetamine sulfate and dextroamphetamine sulfate, Smith Kline & French Laboratories) heart-shaped tablets.

Hemp - marijuana.

Herb - slang term sometimes used for marijuana.

Hog - phencyclidine-hydrochloride.

Horse - heroin.

J - a joint or marijuana cigarette.

Joint - a marijuana cigarette.

Junk - narcotics.

Junkie - a narcotic addict.

Key - a kilogram of a drug, especially a brick of marijuana compressed into a 2.2 lb (kg.) block.

Lady - one of many terms for cocaine.

Lemons, Ludes - street terms for methaqualone.

Lid - a loose term for a quantity of marijuana, usually about an ounce.

Locoweed - marijuana.

M - morphine.

Machinery - equipment for injecting drugs.

Mainline - to inject a drug into a vein.

Mary Jane - marijuana.

Meth - methamphetamine, usually injected for rapid result.

Mickey Finn - chloral hydrate.

Mike - a street term for a microgram of drug (1/1,000,000 gm.), usually LSD. A typical dose may range from 100 to 250 micrograms.

Mojo - narcotics.

Nickel Bag - a five-dollar purchase of narcotics.

Nimby - "Nembutal" (brand of pentobarbital, Abbott Laboratories) capsules.

O.D. - overdose or fatal amount of narcotics.

Oranges - "Dexedrine" (brand of dextroamphetamine sulfate, Smith Kline & French Laboratories) tablets.

Peaches - "Benzedrine" (brand of amphetamine sulfate, Smith Kline & French Laboratories) tablets.

P.G. or P.O. - paregoric.

Pinks - "Seconal" (brand of secobarbital, Eli Lilly and Company) capsules.

Pink Footballs - a pink football-shaped drug containing amphetamines.

Pop - to inject drugs.

Pot - marijuana.

Rainbows - "Tuinal" (brand of amobarbital sodium and secobarbital sodium, Eli Lilly and Company) capsules

Red Devils - "Seconal" (brand of secobarbital, Eli Lilly and Company) capsules.

Reefer - a marijuana cigarette.

Rope - marijuana.

Roses - "Benzedrine" (brand of amphetamine sulfate, Smith Kline & French Laboratories) tablets.

Scag - heroin.

Seggy - "Seconal" (brand of secobarbital, Eli Lilly and Company) capsules.

Sinsemilla - a high-potency, seedless variety of marijuana that is grown in California, Hawaii, and other favorable locations.

Snort - to inhale a drug through the nose in a manner similar to that used in taking tobacco snuff. Cocaine is probably the most common drug consumed in this way.

Snow - cocaine.

Speed - methamphetamine, usually injected for rapid result.

Speedball - an injection which combines a stimulant and depressant—often cocaine mixed with morphine or heroin.

STP - a highly potent hallucinogen.

Strung Out - to be seriously dependent on a drug and have evident effects from its use or from the withdrawal symptoms following its discontinuance.

THC - a shortened term for delta-9-tetrahydrocannabinol, the principal psychoactive ingredient in marijuana. PCP or phencyclidine is sometimes sold on the street masquerading as THC. Because of the difficulty of synthesizing THC, it is unlikely that street THC is ever genuine.

Tooies - "Tuinal" (brand of amobarbital sodium and secobarbital sodium, Eli Lilly and Company) capsules.

Weed - marijuana.

Weed-head - marijuana user.

Whites - amphetamine sulfate tablets.

White stuff - morphine.

Yellows and Yellow Jackets - a street term for Nembutal capsules.

BLOOD ALCOHOL CONCENTRATION (BAC) CHART

	1 Drink				2 Drinks				3 Drinks				4 Drinks			
After hours	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
Weight pounds																
80	—	—	—	.02	—	—	.05	.06	.07	.10	.10	.10	.12	.12	.15	.15
100	—	—	—	.02	—	—	.04	.06	.05	.07	.08	.09	.09	.10	.12	.13
120	—	—	—	.02	—	—	.03	.04	.03	.04	.06	.08	.06	.08	.09	.11
140	—	—	—	.01	—	—	.02	.04	.02	.03	.05	.06	.04	.06	.08	.09
160	—	—	—	.01	—	—	.02	.03	.01	.02	.04	.05	.03	.04	.06	.08
180	—	—	—	.01	—	—	.01	.03	—	.02	.03	.04	.02	.04	.05	.07
200	—	—	—	—	—	—	.01	.02	—	.01	.03	.04	.01	.03	.04	.06

	5 Drinks				6 Drinks				7 Drinks				8 Drinks			
After hours	4	3	2	1	4	3	2	1	4	3	2	1	4	3	2	1
Weight pounds																
80	.17	.17	.19	.20	.19	.22	.22	.25	.25	.27	.27	.30	.29	.30	.32	.33
100	.13	.14	.16	.17	.16	.18	.19	.21	.20	.22	.23	.25	.24	.25	.27	.28
120	.09	.11	.13	.14	.13	.14	.16	.17	.15	.17	.19	.20	.19	.20	.22	.23
140	.07	.09	.10	.12	.10	.12	.13	.15	.13	.14	.16	.17	.15	.17	.18	.20
160	.06	.07	.09	.10	.08	.09	.11	.13	.10	.12	.13	.15	.13	.14	.16	.17
180	.04	.06	.07	.09	.06	.08	.09	.11	.09	.10	.12	.13	.11	.12	.14	.15
200	.03	.04	.06	.08	.05	.07	.08	.09	.07	.09	.10	.12	.09	.10	.12	.13

This chart may be used to determine approximate BAC after a period of drinking.

DRINKING MYTHS

The following is a modern mythology of drinking, dedicated to the idea that what we think we know can hurt us. Why bother to de-bunk a bunch of harmless myths about drinking? Because they're not so harmless. For instance?-- If a guy thinks it's okay to smash down 8 or 10 beers every night because "it's only beer", he could develop a serious problem without even knowing it.

We have ten million alcoholic Americans. It's become a national plague. Yet in some other societies, where they don't share our misconceptions about drinking, alcoholism is rare. So the more who know about drinking, the better we can handle it and decide whether, where, when, why, how much, and with whom to drink.

Myth: Most alcoholics are skid row bums.
Only 3% to 5% are on skid row. Alcoholics are representative of a cross-section of Americans.

Myth: Most skid row bums are alcoholics.
No, less than half of those living on skid row have drinking problems.

Myth: Very few women become alcoholic.
In the 1950's, there were five or six known alcoholic men to every known alcoholic woman. Now the ratio is about three to one. This may be due to better reporting.

Myth: Most alcoholic people are middle-aged or older.
A University of California research team has found that the highest proportion of drinking problems is among men in their early 20's. The second-highest incidence occurs among men in their 40's and 50's.

Myth: You're not alcoholic unless you drink a pint a day.
There's no simple rule of thumb. Experts have concluded that how much one drinks may be far less important than when, how, and why one drinks.

Myth: The "drunk tank" is a good cure for alcoholism.
Alcoholism is an illness, and can be treated successfully. We don't jail people for other illnesses; why for alcoholism?

Myth: "I don't know any alcoholics."
Maybe you don't know you know any alcoholics. Some of your best friends may have drinking problems. They don't seem "different". And they usually try to hide their illness, even from themselves. About one of every ten executives has a drinking problem.

Myth: The really serious problem in our society is drug abuse.
That's true, but our number one drug problem is alcohol abuse. Alcohol is a drug. About 300,000 Americans are addicted to heroin, but about 10,000,000 are addicted to alcohol. It's not even close.

Myth: People get drunk ... or sick ... from switching drinks.
That shouldn't really make much difference. What usually causes an adverse reaction to alcohol is how much a person drinks ... and when and why.

Myth: "It's only beer."
Sure, just like it's only bourbon, or vodka, or gin. One beer or one glass of wine is about equal in alcohol content to one average highball. The effect might be a little slower, but you'll get just as drunk on beer or wine as on hard liquor.

Myth: Some people can really "hold their liquor".
Often, the person who can hold so much is developing a tolerance for alcohol. Tolerance is one of the first signs of alcoholism.

Myth: "I drive better after a few drinks."
In most states, the legal definition of "driving under the influence" is a blood alcohol concentration (BAC) of 0.10%. But scientific tests have proven that even professional drivers' abilities diminish sharply at levels as low as 0.03% ... just a few drinks. At those levels, judgement is affected. So people think they're driving better while they're really driving worse.

Myth: Alcohol is a stimulant.
It's about as good a stimulant as ether. Alcohol may cause temporary psychological excitement. However, alcohol acts as a depressant on the central nervous system.

Myth: "What a man—still on his feet after a whole fifth."
When we stop thinking it is manly to drink too much, we have begun to grow up. It's no more manly to over-drink than it is to over-eat.

Myth: Drinking is a sexual stimulant.
Contrary to popular belief, the more you drink, the less your sexual capacity. Alcohol may stimulate interest in sex, but it interferes with the ability to perform.

Myth: Getting drunk is funny.
Maybe it is in old Charlie Chaplin movies ... but not in real life. Drunkenness is no funnier than any other illness or incapacity.

Myth: "I'm just a social drinker."
Just because you never drink alone doesn't mean you can't have a drinking problem. Plenty of "social drinkers" become alcoholic.

Myth: A good host never lets a guest's glass get empty.
There's nothing hospitable about pushing alcohol or any other drug. A good host doesn't want his guests to get drunk or sick. He wants them to have a good time ... and remember it the next day.

Myth: People are friendlier when they are drunk.
Maybe. But they are also more hostile, more dangerous, more criminal, more homicidal, and more suicidal. One-half of all murders and one-third of all suicides are alcohol-related.

Myth: "Give him black coffee. That will sober him up."
Sure, in about five hours. Cold showers don't work either. Only time can get the alcohol out of the system, as the liver metabolizes the alcohol. There's no way to hurry it.

Myth: The best cure for a hangover is ...
Everybody has his favorite. But they all have one thing in common—they don't work. What works?—preventive medicine. If you don't drink too much, you won't get a hangover.

Myth: Today's kids don't drink.
The generation gap is greatly exaggerated. The kids' favorite drug is the same as their parents' favorite—alcohol. And drinking problems are rising among the young.

Myth: If the parents don't drink, the children won't drink.
Sometimes that's true. But the highest incidence of alcoholism occurs among offspring of parents who are either teetotalers ... or alcoholic. Perhaps the extremes of attitudes of the parents is an important factor.

Myth: The time to teach kids about drinking is when they reach legal age.
By that time, they've long since learned what we can teach them. We teach kids from birth, and they learn more from what they see us do than from what they hear us tell them.

Myth: "Thank God my did isn't on drugs!"
If he's hooked on drinking, he's on drugs. With ten million Americans dependent on alcohol, it's time we stopped pretending it isn't a drug.

Myth: It's rude to refuse a drink.
What's rude is trying to push a drink on someone who doesn't want it … or shouldn't have it.

Myth: It's impolite to tell a friend he's drinking too much.
Maybe if we weren't all so "polite," we wouldn't have so many friends with drinking problems.

Myth: Alcoholism is just a state of mind.
It's more than that—it's a very real illness. There is scientific evidence that physiological dependence is involved.

Myth: The first round should be a "double" to break the ice.
Breaking the ice is a job for a good host and hostess … not for a bottle. You must have more to give your guests than just alcohol.

Myth: Mixing your drinks causes hangovers.
The major cause of hangovers is drinking too much.

Myth: Indians can't drink; Jews don't drink.
Some can and some can't; some do and some don't.

Myth: People who drink too much hurt only themselves.
They hurt themselves, their families, their friends, their employers, strangers on the highway, and you.

Myth: Your kids will learn what you tell them about drinking.
Your kids will learn what you show them about drinking. If you drink heavily, if you get drunk, the chances are that your kids will follow your example.

Myth: Never trust a person who never takes a drink.
You know that's silly. Yet many people are a little nervous around a person who doesn't drink.

EFFECTS OF MARIJUANA ON THE BODY

The Effects of Marijuana on the Respiratory System

Marijuana use increases the chance of upper respiratory infections, and may trigger susceptibility to diseases like asthma and chronic bronchitis. Marijuana smoke is more destructive to the body than tobacco smoke. Marijuana smoke contains over 150 different chemicals capable of causing cancer. Pot smoking interferes with the respiratory system

- Breathing Capacity. Smoking marijuana reduces the amount of air that can be taken in and out of the lungs. This effect is primarily due to a narrowing of the bronchial tubes caused by marijuana smoke.

- Susceptibility. Marijuana smoke weakens the lungs' ability to fight off disease. The lungs have special cells called macrophages which destroy disease—producing bacteria. For at least six hours after smoking a joint, these cells do not operate properly.

- Bronchitis. Bronchitis is the medical term for inflammation of the bronchial tubes, the breathing tubes which take air from the windpipe to the lungs. The symptoms of bronchitis include slight fever, discomfort in the chest, and a nagging cough. Many times the patient will cough up yellowish-green mucus from the lungs. If the coughing is violent or if other lung disease is present, the mucus may be tinged with blood.

- Lung Cancer. Lung cancer is the leading cause of cancer death, and the vast majority of lung cancer is caused by cigarette smoking. Over 75,000 Americans die each year from lung cancer. Marijuana smoke has even more cancer-causing chemicals than tobacco smoke. In terms of impaired lung function, smoking a marijuana joint is equivalent to smoking nearly a pack of cigarettes. Much of this impairment is due to the fact that marijuana smoke is typically inhaled deeply for as long as possible.

The Effects of Marijuana on Blood Pressure

- Heart Rate Abnormalities. The degree of rapid heart rate, which is related to the dose of THC absorbed, reaches a maximum 30 minutes after smoking and persists for more than 40 minutes. When the heart rate and blood pressure are elevated, circulatory problems can develop. Those with heart conditions should not smoke marijuana.

- Conjunctival Congestion. Conjunctival congestion (bloodshot eyes) occurs after smoking marijuana. It is associated with elevated blood pressure.

The Effects of Marijuana on Cell Function

The outer wall of the cell is a delicate membrane 7-8 millionths of a millimeter thick, made up of a double layer of fat molecules sandwiched between two layers of protein. Materials are absorbed by the surface area of the cell and carried through the fat molecules and the layers of protein into the cells.

- When the fat molecules in the cell surface are clogged with THC, materials (food, protein, amino acid, sugar) are blocked from crossing the cell surface at the normal rates. The amount of blockage and resultant abnormalities depends on the amount of the THC entering the cell surface.

- Marijuana disrupts proper cell division. Cells "under the influence" often do not split apart to make new cells correctly. THC prevents the proper formation of DNA, RNA, and proteins.

- Marijuana can lower the body's immune reaction and ability to fight infections because THC affects the functioning of white blood cells.

The Effects of Marijuana on the Nervous System

THC causes the synaptic cleft, or the area between each nerve cell, to enlarge. The result is less effective transmission between cells.

- Memory. Marijuana impairs brain cells in the hippocampus region of the brain and, as a result, marijuana users may have difficulty concentrating or focusing on a topic for any sustained length of time. This is one of the most common effects.

- Motivation. The marijuana user often loses interest in vigorous activities. He becomes fatigued, depressed, and moody and experiences an inability to cope. Mind-altering drugs provide a quick and simple escape from the stresses that are a normal part of growing up, but the user never learns to cope with those stresses.

- Emotion. THC seems to damage brain cells, especially in the limbic system, which is involved with emotion and which can produce unexpected changes in mood.

- Vision. Brain cells in the occipital area of the brain can be damaged resulting in blurred vision and irregular visual perception.

- Sleep. When the brain cells in the hypothalmus area of the brain are damaged, irregular sleeping habits and insomnia may result.

- Body Coordination. The cerebellum is important for the coordination of body movements and the maintenance of posture and balance. When these brain cells are damaged in the cerebellum, psychomotor performance is affected.

- Speech-Comprehension. When the cortex area of the brain is affected, impairment of the ability to understand relationships and to express complex ideas occurs

- Brain Cells. In animal studies, heavy marijuana use produces changes in the structure of brain cells. The most common abnormalities are "swelling" of the cells and the presence of "cellular garbage".

- Brain Waves. THC changes brain wave patterns

  -- In a study of 50 teenagers who had smoked at least three joints a week for four months, 48 of the 50 had abnormal (slower) brain waves when they attempted mental tasks. The mental tasks included ones such as computing math problems in their heads and spelling words forward and backward. When the teenaged pot smokers were forced to think quickly, their brain waves could not "speed up" to deal with the mental challenge.

  -- Surgical implants in monkeys to measure "deep brain" functioning show changes in the brain waves related to pleasure and emotion. Abnormal brain wave patterns lasted one month after stopping heavy marijuana use (several joints daily for six months).

  -- Studies with rats also demonstrate abnormal brain waves in the "deep brain" when given marijuana. Such studies on people are not practical because surgical implants inside the brain are necessary for EEG measurement of the deep brain.

The Effects of Marijuana on the Reproductive System

The cells of the reproductive system, like those in the respiratory and nervous systems, attract a heavy THC content.

- Decreased Male Masculinity. Marijuana use may restrict the normal growth of sperm-producing cells, causing the function of the testes to be underdeveloped.

- Infertility in Males. Moderate-to-heavy marijuana use, especially during the years 12-17, causes deficiency in testosterone production and can result in production of no sperm, too little sperm or abnormal sperm. These conditions of sperm deficiency directly affect the male's ability to fertilize the female egg.

- Decreased Femininity. In contrast, testosterone levels in females increase as a result of marijuana use. Females tend to take on such male secondary sexual characteristics as hair on chest, face and arms, and they also experience more serious acne problems. The adolescent female may not develop fat deposits on hips, buttocks, breasts or upper arms.

- Pregnancy Dangers. Embryo toxicity seems to be related to the disrupting effects of THC on the passage of nutrients from the placenta to the fetus. Infant mortality rates increase with marijuana use. A breast feeding mother may also transfer THC to her baby.

The Effects of Marijuana on the Immune System

There is substantial evidence that regular marijuana use produces a slightly weakened immune, or defense, system to counteract viruses, bacteria, and funguses. The most extensive studies have beeen done with animals. Studies with humans show impairment of the immune system when more sensitive tests are done. Less sensitive tests show little or no weakness in the immune system.

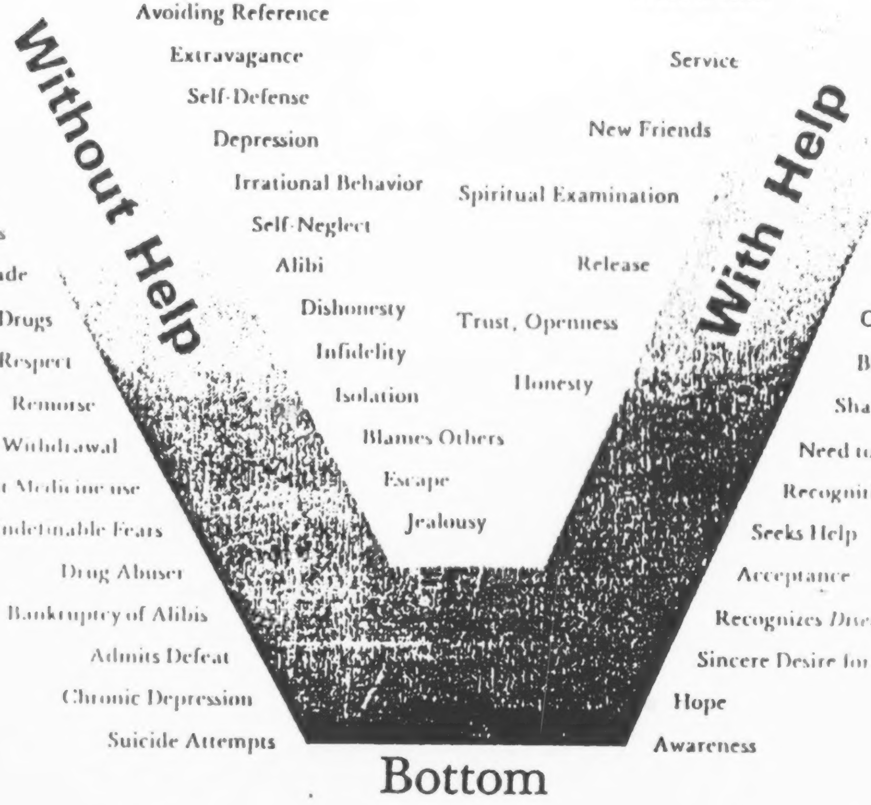
It is not clear whether marijuana smokers get more colds, flu, and cancer than non-smokers. Such a study would involve thousands of people and would require an extended period of time and substantial cost. It is clear that marijuana does at least slight harm to cells involved in body defense.

AIDS TESTING AND COUNSELING SITES

Free AIDS testing and counseling are available, as of May 1988, at the following locations:

Cape Girardeau 314-335-7846	**Cape Girardeau County Nursing Service** 44 North Lorimer - Cape Girardeau, MO 63701
Columbia 314-874-7355	**Columbia-Boone County Health Department** 600 East Broadway - Columbia, MO 65205
Flat River 314-431-1947	**St. Francois County Health Department** 1025 W. Main Street - Flat River, MO 63601
Independence 816-881-4424	**Jackson County Health Department** 313 South Liberty - Independence, MO 64050
Jefferson City 314-636-2181	**Cole County Health Department** 210 Adams Street - Jefferson City, MO 65101
Joplin 417-623-6122	**Joplin City Health Department** 513 Kentucky Avenue - Joplin, MO 64801
Kansas City 816-231-8895	**Kansas City Free Health Clinic** 5119 East 24th Street - Kansas City, MO 64127
Kansas City 816-923-2600	**Kansas City Health Department** 1423 E. Linwood Blvd. - Kansas City, MO 64109
Macon 816-385-4711	**Macon County Health Department** 1131 Jackson - Macon, MO 63552
Marshall 816-886-3434	**Saline County Nursing Service** 76 West Arrow - Marshall, MO 65340
Springfield 417-864-1686	**Springfield-Greene County Health Department** 227 E. Chestnut Expressway - Springfield, MO 64802
St. Joseph 816-271-4725	**St. Joseph/Buchanan County Health Department** 904 South 10th Street - St. Joseph, MO 64503
St. Louis Metro 314-854-6143	**St. Louis County Health Department** 601 S. Brentwood - Clayton, MO 63105
314-658-1159	**St. Louis City Division of Health** 634 North Grand-4th Floor - St. Louis, MO 63178

THE PROGRESSION AND RECOVERY OF THE FAMILY IN THE DISEASE OF ALCOHOLISM



Blues
Intolerance
Suspicion
Problems Multiplying
Worry
Irritability
Seeks Help
Avoiding Reference
Extravagance
Self-Defense
Depression
Irrational Behavior
Self-Neglect
Alibi
Dishonesty
Infidelity
Isolation
Blames Others
Escape
Jealousy

Arguments
Distrust
Unhappiness
Religious Needs
Denial (fantasy)
Threats Made and Not Carried Through
Takes Responsibility
Loss of Interest
Imaginary Illnesses
Facade
Uses Prescribed Drugs
Loss of Self Respect
Remorse
Social Withdrawal
Patent Medicine use
Indefinable Fears
Drug Abuser
Bankruptcy of Alibis
Admits Defeat
Chronic Depression
Suicide Attempts

Courage
Love
Makes Amends
Peace of Mind
Service
New Friends
Spiritual Examination
Release
Trust, Openness
Honesty

At Ease with Life
Happiness
Return of Respect of Family and Friends
Appreciates Spiritual Values
Return of Confidence
New Interests Develop
Guilt is Gone
Return of Self-Esteem
Diminishing Fears
Daily Living Pattern Changes (Rest, Diet, Sleep)
Developing Optimism
Begins to Relax
Cover Up Ceases
Becomes Willing to Change
Shares with Others
Need to Control Lessens
Recognition of Role
Seeks Help
Acceptance
Recognizes *Disease*
Sincere Desire for Help
Hope
Awareness

The progression and recovery symptoms listed are based on the most repeated experiences of family members in the disease of alcoholism or other chemical dependencies. While every symptom in the chart does not occur in every member of every family, or in the same sequence, it does portray an *average* chain reaction. The entire process may take years or it may ocur in a very short time.

C. A. S. T.

______________________ (Name)

______________________ (Date)

Please check (✓) the answer below that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or No."

(Yes)	(No)		
______	______	1.	Have you ever thought that one of your parents had a drinking problem?
______	______	2.	Have you ever lost sleep because of a parent's drinking?
______	______	3.	Did you ever encourage one of your parents to quit drinking?
______	______	4.	Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?
______	______	5.	Did you ever argue or fight with a parent when he or she was drinking?
______	______	6.	Did you ever threaten to run away from home because of a parent's drinking?
______	______	7.	Has a parent ever yelled at or hit you or other family members when drinking?
______	______	8.	Have you ever heard your parents fight when one of them was drunk?
______	______	9.	Did you ever protect another family member from a parent who was drinking?
______	______	10.	Did you ever feel like hiding or emptying a parent's bottle of liquor?
______	______	11.	Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
______	______	12.	Did you ever wish that a parent would stop drinking?
______	______	13.	Did you ever feel responsible for and guilty about a parent's drinking?
______	______	14.	Did you ever fear that your parents would get divorced due to alcohol misuse?
______	______	15.	Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
______	______	16.	Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
______	______	17.	Did you ever feel that you made a parent drink alcohol?
______	______	18.	Have you ever felt that a problem drinking parent did not really love you?
______	______	19.	Did you ever resent a parent's drinking?
______	______	20.	Have you ever worried about a parent's health because of his or her alcohol use?
______	______	21.	Have you ever been blamed for a parent's drinking?
______	______	22.	Did you ever think your father was an alcoholic?
______	______	23.	Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
______	______	24.	Did a parent ever make promises to you that he or she did not keep because of drinking?
______	______	25.	Did you ever think your mother was an alcoholic?
______	______	26.	Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
______	______	27.	Did you ever fight with your brothers and sisters about a parent's drinking?
______	______	28.	Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
______	______	29.	Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
______	______	30.	Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

Children of Alcoholics Screening Test (C.A.S.T.)
Scoring Guidelines

A YES answer to 0 - 1 question indicates children of non-alcoholics.

A YES answer to 2 - 5 questions indicates children of problem drinkers.

A YES answer to 6 or more questions indicates children of alcoholics.

ROLES, TRAITS AND PROBABLE OUTCOMES FOR CHILDREN OF ALCOHOLICS

	VISIBLE QUALITIES	INNER FEELINGS	REPRESENTS TO FAMILY	TRAITS	POSSIBLE FUTURE CHARACTERISTICS	
					WITHOUT HELP	WITH HELP
FAMILY HERO	Visible success Does what is right	Inadequate	Self-Worth (Family can be proud)	High Achiever Grades Friends Sports	Workaholic Never wrong Responsible for everything Marry dependent	Accept failure Responsible for self, not all Good executive
SCAPEGOAT	Hostility Defiance Anger	Hurt Guilt	Takes focus off the alcoholic	Negative attention Won't compete with "family hero"	Unplanned pregnancy Trouble maker in school and later in office Prison	Accept responsibility Good counselor Ability to see reality
LOST CHILD	Withdrawn Loner	Loneliness Unimportant	Relief (One child not to worry about)	"Invisible" — Quiet No friends Follower Trouble making decisions	Little zest for life Sexual identity problems Promiscuous or stay alone Often dies at early age	Independent Talented Creative Imaginative
MASCOT	Fragile Immature Needs protection	Fear	Fun and humor (Comic relief)	Hyperactive Learning disabilities Short attention span	Ulcers, can't handle stress Compulsive clown Marry "hero" for care	Take care of self No longer clown Fun to be with Good sense of humor

LEVELS OF SUBSTANCE USE BY ADOLESCENTS

Level 1: Use

Irregular, experimental use with friends, usually associated with social acceptance
Acceptable use with parental knowledge (meals, special occasions)
Low tolerance
First hangover
Few consequences

Level 2: Misuse

Pattern of use develops, generally on weekends, but seldom on weeknights
Occasional excessive use
Starts devising reasons for using (relaxation, social events, impressing others)
Has basic control and choice over use
Starts making self-imposed rules (places, times, amounts)
Tolerance increases
Minor consequences begin

Level 3: Abuse

Uses on weekends and weeknights but seldom on a daily basis
Modifies the self-imposed rules regarding use
Anticipates and plans use
Begins solitary use
Uses at inappropriate times
Makes promises to cut down or quit
Less control and choice over use
Tolerance continues to increase
Occasionally shows irrational behavior or suden mood swings
More consequences occur
Associates mainly with peers who use

Level 4: Dependency

Frequent use, often daily
Preoccupied with chemicals and keeping a constant supply
Solitary use increases
May stay high for extended periods
Loss of control and choice over use
Abandons self-imposed rules
Makes repeated, unsuccessful efforts to control use
Tolerance continues to increase
Exhibits poor emotional control—grandiose, unpredictable, aggressive
Serious consequences occur
Deteriorates rapidly in several life areas—family, social, educational, legal, physical, financial, emotional

SUBSTANCE DEPENDENCE AND ABUSE
DIAGNOSTIC AND STATISTICAL MANUAL III - REVISED

Psychoactive Substance Dependence

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiologic symptoms that indicate that the person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. The symptoms of the dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal.

The symptoms of the dependence syndrome are the same across all categories of psychoactive substance, but for some classes some of the symptoms are less salient, and in a few instances do not apply (e.g., withdrawal symptoms do not occur in Hallucinogen Dependence). At least three of the nine characteristic symptoms of dependence are necessary to make the diagnosis. In addition, the diagnosis of the dependence syndrome requires that some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time, as in binge drinking.

Dependence as defined here is conceptualized as having different degrees of severity, and guidelines for mild, moderate, and severe dependence and dependence in partial or full remission are provided.

Symptoms of Dependence

The following are the characteristic symptoms of dependence. It should be noted that not all nine symptoms must be present for the diagnosis of Dependence, and for some classes of psychoactive substances, certain of these symptoms do not apply.

1. The person finds that when he or she actually takes the psychoactive substance, it is often in larger amounts or over a longer period than originally intended. For example, the person may decide to take only one drink of alcohol, but after taking this first drink, continues to drink until severely intoxicated.

2. The person recognizes that the substance use is excessive, and has attempted to reduce or control it, but has been unable to do so (as long as the substance is available). In other instances the person may want to reduce or control his or her substance use, but has never actually made an effort to do so.

3. A great deal of time is spent in activities necessary to procure the substance (including theft), taking it, or recovering from its effects. In mild cases the person may spend several hours a day taking the substance, but continue to be involved in other activities. In severe cases, virtually all of the user's daily activities revolve around obtaining, using, and recuperating from the effects of the substance.

4. The person may suffer intoxication or withdrawal symptoms when he or she is expected to fulfill major role obligations (work, school, homemaking). For example, the person may be intoxicated when working outside the home or when expected to take care of his or her children. In addition, the person may be intoxicated or have withdrawal symptoms in situations in which substance use is physically hazardous, such as driving a car or operating machinery.

5. Important social, occupational, or recreational activities are given up or reduced because of substance use. The person may withdraw from family activities and hobbies in order to spend more time with substance-using friends, or use the substance in private.

6. With heavy and prolonged substance use, a variety of social, psychological, and physical problems occur, and are exacerbated by continued use of the substance. Despite having one or more of these problems (and recognizing that use of the substance causes or exacerbates them), the person continues to use the substance.

7. Significant tolerance, a markedly diminshed effect with continued use of the same amount of the substance, occurs. The person will then take greatly increased amounts of the substance in order to achieve intoxication or the desired effect. This is distinguished from the marked personal differences in initial sensitivity to the effects of a particular substance.

   The degree to which tolerance develops varies greatly across classes of substances. Many heavy users of cannabis are not aware of tolerance to it, although tolerance has been demonstrated in some people. Whether there is tolerance to phencyclidine (PCP) and related substances is unclear. Heavy users of alcohol at the peak of their tolerance can consume only about 50% more than they originally needed in order to experience the effects of intoxication. In contrast, heavy users of opioids often increase the amount of opioids consumed to tenfold the amount they originally used—an amount that would be lethal to a nonuser. When the psychoactive substance used is illegal and perhaps mixed with various diluents or with other substances, tolerance may be difficult to determine.

8. With continued use, characteristic withdrawal symptoms develop when the person stops or reduces intake of the substance. The withdrawal symptoms vary greatly across classes of substances. Marked and generally easily measured physiologic signs of withdrawal are common with alcohol, opioids, sedatives, hypnotics, and naxiolytics. Such signs are less obvious with amphetamines, cocaine, nicotine, and cannabis, but intense subjective symptoms can occur upon withdrawal from heavy use of these substances. No significant withdrwal is seen even after repeated use of hallucinogens; withdrawal from PCP and related substance has not yet been described in humans, although it has been demonstrated in animals.

9. After developing unpleasant withdrawal symptoms, the person begins taking the substance in order to relieve or avoid those symptoms. This typically involves using the substance throughout the day, beginning soon after awaking. This symptom is generally not present with cannabis, hallucinogens, and PCP.

Diagnostic Criteria for Psychoactive Substance Dependence

At least three of the following:

1. Substance often taken in larger amounts or over a longer period than the person intended.

2. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.

3. A great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance, or recovering from its effects.

4. Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated).

5. Important social, occupational, or recreational activities given up or reduced because of substance use.

6. Continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking).

7. Marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

Note: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP).

8. Characteristic withdrawal symptoms.

9. Substance often taken to relieve or avoid withdrawal symptoms.

Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

Criteria for Severity of Psychoactive Substance Dependence

Mild: Few, if any smptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

Moderate: Symptoms or functional impairment between "mild" and "severe".

Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

In Partial Remision: During the past six months, some use of the substance and some symptoms of dependence.

In Full Remission: During the past six months, either no use of substance, or use of the substance and no symptoms of dependence.

Psychoactive Substance Abuse

Psychoactive Substance Abuse is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance. The maladaptive pattern of use is indicated by either (1) continued use of the psychoactive substance depsite knowledge of having a persistent or recurrent social, occupation, psychological, or physical problem that is caused or exacerbated by use of the substance or (2) recurrent use of the substance in situations when use is physically hazardous (e.g., driving while intoxicated). The diagnosis is made only if some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time.

This diagnosis is most likely to be applicable to people who have only recently started taking psychoactive substances and to involve substances, such as cannabis, cocaine, and hallucinogens, that are less likely to be associated with marked physiologic signs of withdrawal and the need to take the substance to relieve or avoid withdrawal symptoms.

Examples of situations in which this category would be appropriate are as follows:

1. A college student binges on cocaine every few weekends. These periods are followed by a day or two of missing school because of "crashing". There are no other symptoms.
2. A middle-aged man repeatedly drives his car when intoxicated with alcohol. There are no other symptoms.
3. A woman keeps drinking alcohol even though her physician has told her that it is responsible for exacerbating the symptoms of a duodenal ulcer. There are no other symptoms.

Diagnostic Criteria for Psychoactive Substance Abuse

1. A maladaptive pattern or psychoactive substance use is indicated by at least one of the following:
    - Continued use despite knowledge of having a persistent or recurrent social, occupational psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance.
    - Recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated).
2. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.
3. Never met the criteria for Psychoactive Substance Dependence for this substance.

Classes of Psychoactive Substances

Nine classes of psychoactive substance are associated with both abuse and dependence: alcohol; amphetamine or similarly acting sympathomimetics; cannabis; cocaine; hallucinogens; inhalants; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylmines; and sedatives, hypnotics or anxiolytics.

BARRIERS TO TREATMENT FOR ADOLESCENTS

One of the common barriers to successful treatment for adolescent substance abusers is their tendency to believe themselves different from their peers and not like those who are used as examples or as part of statistics. This belief in being different is probably due to the adolescents limited life experience and to their inability to conceptualize cause and effect in a way that applies to them. Adolescents tend to believe themselves not only to be different, but also to be "bullet proof" or immortal. Even if they do intellectually realize that a particular act might be dangerous or risky, it generally is perceived so for others, but not for themselves.

Another difficulty to surmount in the treatment of adolescents is their tendency to perceive the immediate difficulty not so much as a result of what they are doing as it is a result of their age or status. They sometimes see adults drinking or doing drugs with apparent impunity. The adults are doing the same thing the adolescent does and appear to be paying no price for it. So, sometimes the fault, as they see it, is not their behavior but their age, a condition which is temporary and one from which they will soon recover.

In order to obtain treatment, it is often necessary for both the adolescent and his or her parent to consent to treatment. Getting both parties to recognize and accept the need for treatment may be difficult, because denial is a primary symptom of substance abuse. Denial within both the adolescent and the family must be overcome before help is sought. Once the decision in made to obtain treatment, a treatment program may not be readily available. Specialized programs for adolescents are somewhat limited in number.

If the adolescent enters a treatment program, therapeutic progress may be hindered by the adolescents' tendency toward lack of trust, openness, and honesty with adults. This can make progress and change difficult or slow. Sometimes the progress and cooperation which the adolescent appears to be demonstrating is nothing more than simple compliance—an appearance of change when in reality there has been no change. This superficial appearance of progress may lull those related to the adolescent (counselors, family members, and others) into believing that the client has developed new behaviors and attitudes, when in reality the adolescent is only doing what is necessary to get by.

FILM/VIDEO RESOURCES

AA General Services Office
P.O. Box 459
Grand Central Station
New York, NY 10163
(212) 686-1100

AAA Foundation for Traffic Safety
8111 Gatehouse Road
Falls Church, VA 22042
(703) 222-2062

AIMS Media
6901 Woodley Avenue
Van Nuys, CA 91406-4878
(800) 367-2467

Alanon Family Group, Inc.
P.O. Box 862, Midtown Station
New York, NY 10018
(212) 302-7240

Alfred Higgins Productions, Inc.
9100 Sunset Blvd.
Los Angeles, CA 90069
(213) 272-6500

All About Media, Inc.
4306 Crenshaw Blvd.,
Suite 105
Los Angeles, CA 90008
(213) 777-1000

Barr Films
12801 Schabarum
P.O. Box 7878
Irvindale, CA 91706
(800) 234-7878

Cambridge Documentary Films, Inc.
P.O. Box 385
Cambridge, MA 02139
(617) 354-3677

Carousel Film and Video
241 E. 34th Street
New York, NY 10016
(212) 683-1600

Channing L. Bete Co., Inc.
200 State Road
South Deerfield, MA 01373
(800) 421-4609

Churchill Films
662 N. Robertson Blvd.
Los Angeles, CA 90069
(213) 657-5110

Cinemed Inc.
P.O. Box 96
Ashland, OR 97520
(503) 488-2805

Coronet-MTI Film and Video
108 Wilmot Road
Deerfield, IL 60015
(800) 621-2131

Doron Precision Systems, Inc.
P.O. Box 400
Binghampton, NY 13902
(607) 772-1610

FMS Productions, Inc.
P.O. Box 4428
Santa Barbara, CA 93140
(800) 421-4609

Gary Whiteaker Corporation
P.O. Box 307
Belleville, IL 62222
(618) 476-7771

Gerald T. Rogers Productions, Inc.
5225 Old Orchard Road, Suite 23
Skokie, IL 60077
(800) 227-9100

Insurance Information Institute
110 William Street
New York, NY 10038
(212) 669-9200

Johnson Institute
510 First Avenue North
Minneapolis, MN 55403-1607
(612) 341-0435

Kemper Group
Kemper Television Center
F-6 Long Grove, IL 60049
(312) 540-2819

Melear Multi-Media
1344 Johnson Ferry Road
Suite 14
Marietta, GA 30068
(404) 971-5665

MTI Teleprograms, Inc.
3710 Commercial Avenue
Northbrook, IL 60062
(800) 323-5343

National Council on Alcoholism
and Drug Abuse - St. Louis Area
8790 Manchester Road
St. Louis, MO 63144
(314) 962-3456
(Film/Video Rental)

New Day Films
22 Riverview Drive
Wayne, NJ 07470-3191
(201) 633-0212

Onsite Training and Consultants, Inc.
2820 West Main
Rapid City, SD 57702
(605) 341-7432

S/P Associates
1113 South Pearl Street
Denver, CO 80201
(303) 733-1980

South Carolina Commission on Alcohol
and Drug Abuse
3700 Forest Drive
Columbia, SC 29204

Speas Resource Center
616 East 63rd Street
Kansas City, MO 64110
(816) 444-0642
(Film/Video Rental)

Sunburst Communications
101 Castleton Street
Pleasantville, NY 10570
(800) 431-1934

VISUCOM
P.O. Box 5472
Redwood City, CA 94063
(800) 222-4002

FILM REVIEWS

"Alateen Tells It Like It Is"

This 16 minute video is available from Alanon Family Group Headquarters for $25. It is a candid sharing by Alateens about what it is like to be raised in a home where alcoholism was present.

"Bridging the GAP"

This 20 minute production can be purchased from FMS Productions on film for $430 and on videocassette for $390. It can also be rented from Speas Resource Center. Adolescents positively discuss different aspects of sobriety and recovery in a group therapy treatment setting.

"Chemical People"

Consists of 4 units, 15 minutes each. Available from Coronet-MTI Films and Video for $120 total. This film addresses issues of peer pressure, self-image, self-discipline and decisionmaking. Narrated by Melissa Gilbert, Todd Bridges, Lorenzo Lamas, and Eric Estrada.

"Driving Under the Influence"

This 22 minute film is available from Alfred Higgins Productions for $485. It can be used to support discussion on drinking and driving. Family members of victims, victims, and drunk drivers discuss the impact DWI has had on their lives.

"Drug Profiles"

Available from AIMS Media as a video for $395 or as a 16 mm film for $495. It discusses common substances of abuse in a factual manner, including their effects and history.

"Drugs and Driving: Double Trouble"

This 19 minute film can be purchased from Barr Films for $460 or rented from St. Louis National Council on Alcoholism. It portrays five individuals who attempt to deny the connection between substance use and driving skills. Emphasizes that combining alcohol and drugs increases risk.

"DWI Decision"

This 19 minute film can be purchased from VISUCOM for $475 or rented for $90. It consists of three short segments: (1) How alcohol affects the body; (2) Psychological effects of alcohol; and (3) Decisions about the use of alcohol.

"Family Trap"

This 30 minute production can be purchased from Onsite on film for $390 and on videocassette for $195. It may be rented from Speas Resource Center. It reviews the roles and dynamics in a family with a chemically dependent member. Describes the roles of Enabler, Family Hero, Scapegoat, Lost Child and Mascot.

"Friday Night Five"

This 27 minute production is available from Gerald T. Rogers Productions on film for $510 and on videocassette for $460. It portrays the drinking and driving episodes of five different drivers. Illustrates the differences between and types of drinking drivers.

"Hazards of Drugged Driving"

Produced for Mazda Motors and distributed by Melear Multi-Media as a two part, 30 minute video which can be purchased for $195. Explains how the body and brain are impaired by substance use, making driving unsafe. Offers a series of tips to help teens protect themselves and their friends from the tragedy of a drinking/drugging automobile accident.

"How Can I Tell If I'm Hooked?"

This production is available from Sunburst Communications as two filmstrips on videocassette (26 minutes total time) for $139.

Part 1: Recognizing the Signs - 13 minutes. Portrays teenagers who are progressing toward addiction. Describes the criteria of addiction—compulsion, loss of control, continuing use despite problems, and denial.

Part 2: Patterns of Addiction - 13 minutes. Examines the concept of addiction in its broadest context, including eating and risk taking behaviors. (Part 2 may not be relevant to ADEP.)

"How to Make Good Decisions"

Available from Sunburst Communications as three filmstrips on videocassette (38 minutes total time) for $165.

Part 1: Decisions and Values - 10 minutes. Lists different types of decisions: the routine decision, decision by default, and the reasoned decision.

Part 2: The Five Step Procss - 15 minutes. Presents a step-by-step guide to decisionmaking: (1) identify the problem, (2) search out and identify alternatives, (3) evaluate alternatives, (4) choose an alternative and develop a plan of action, (5) evaluate your choice and, if necessary choose another alternative.

Part 3: Group Decision Making - 13 minutes. Explores the problems groups face in trying to reach decisions. (Much of Part 3 may not be relevant to ADEP as it focuses on group decisionmaking in a student committee.)

"Marijuana and Human Physiology"

This 22 minute production can be purchased from AIMS Media on film for $475 and on videocassette for $375. It is also available from Speas Resource Center. A physician discusses the effects of THC on the body, the person, and the family.

"Medical Aspects of Mind Altering Drugs"

This 30 minute film can be purchased from FMS Productions for $495 and may be rented from the Speas Resource Center. Dr. Max Schneider discusses drugs of abuse and their effects on the mind and body. Substances discussed include alcohol, marijuana, cocaine, designer drugs, PCP, inhalants, and others.

"No Kid of Mine"

This 30 minute video is available from AIMS Media for $195. The parents of addicted children discuss the effects that the alcoholism/drug addiction of their children has had on their families.

"Natural Highs and How to Get Them"

Available from Sunburst Communications as three filmstrips on videocassette (30 minutes total time) for $165.

Part 1: A Way of Life - 10 minutes. Describes different ways to obtain natural highs.

Part 2: Mind Over Matter - 10 minutes. Identifies endorphins as the chemical the brain produces to create natural highs.

Part 3: Taking Charge - 10 minutes. Suggests that natural highs are the answer to stress. Points out that natural highs get easier and better with practice, while drug highs require more and more drugs to achieve poorer and poorer results.

"Sex, Drugs and AIDS"

A first copy of this 18 minute film is available from ODN Productions for $335. Additional copies are $145. It provides clear information on how AIDS is transmitted and what steps can be taken to minimize the risks.

"Steer Clear"

This 20 minute film is available from Gary Whiteaker Corporation for $250 or may be rented from St. Louis National Countil on Alcoholism or Speas Resource Center. It explores the effects of alcohol and marijuana on driving skills under test conditions. Emphasizes that impairment begins at low dose levels.

"Targets"

This 19 minute production is available from Coronet-MTI on film for $450 and on videocassette for $350. It may be rented from St. Louis National Council on Alcoholism or Speas Resource Center. It explores victim roles and how to take personal responsibility. Uses a car accident involving five teenagers to discuss the importance of being your own person.

"Too Good to Waste"

This 22 minute film or videocassette is available from FMS Productions for $450. It presents interviews with teenage alcoholics and drug addicts who are now living clean and sober. It shows young people enjoying sobriety and experiencing their feelings, rather than masking them with substance abuse.

"Turning Off: Drugs and Peer Pressure"

Available from Sunburst Communications as two filmstrips on videocassette (27 minutes total time) for $139.

Part 1: Everybody's Doing It - 13 minutes. Explains that it is deceptive to think a decision to use drugs has been made freely, when actually peer pressure has exerted its powerful influence. Explores group dynamics.

Part 2: Standing Up for Yourself - 14 minutes. Presents a minicourse in assertiveness training using techniques that apply directly to drug use.

"Until I Get Caught"

This 28 minute film or videocassette can be purchased from FMS Productions for $485 or may be rented from St. Louis National Council on Alcoholism or Speas Resource Center. It is useful as a trigger to discuss students' feelings about their responsibility to themselves and society to not drink and drive. Dick Cavett narrates this presentation on the subject of drinking and driving. Included are discussions by family members of those killed by drinking drivers and coments by those who say they will continue to drink and drive.

"Why Me"

This 20 minute film is available from the South Carolina Commision on Alcohol and Drug Abuse for $200. It shows the impact on driving skills of alcohol and alcohol in combination with other drugs. The driving skills of four different people are tested sober, intoxicated with alcohol only, and intoxicated with alcohol and different drugs.

"Young People and AA"

Available from AA World Services as a 28 minute videocassette for $15 and as a 16 mm film for $150. It can be used to help students compare their experiences with those of adolescents recovering from substance dependency. Recovering adolescents relate what their drinking or drugging was like, how they got into recovery, and how their lives have changed. Includes positive references about treatment. - 28 minutes